

**Welcome to**



**Mai Orthodontics**



**Tell us about your child:**

Child's name: \_\_\_\_\_  
Nickname: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
 Male  Female  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Hobbies/ sports: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_



**Person Responsible for Account**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
\_\_\_\_\_  
Hm#: \_\_\_\_\_ Wk# \_\_\_\_\_  
Employer: \_\_\_\_\_  
SS#: \_\_\_\_\_

**Who is responsible for making appointments?**

Name: \_\_\_\_\_



**Who is accompanying your Child Today?**

Name: \_\_\_\_\_  
Relation: \_\_\_\_\_  
Do you have legal custody? \_\_\_\_\_  
Whom may we thank for referring you:  
\_\_\_\_\_  
List brothers/sisters w/age: \_\_\_\_\_  
\_\_\_\_\_  
General Dentist: \_\_\_\_\_  
Last Visit Date: \_\_\_\_\_  
Parent's Marital Status: \_\_\_\_\_  
Are you aware that some appointments will be during school/work hours?  Yes  No



**Primary Orthodontic Insurance**

Orthodontic Coverage?  Yes  No  
Insurance Co. Name: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insurance Co. Phone #: \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy Owner's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Policy Owner's Birthdate: \_\_\_\_\_  
ID# \_\_\_\_\_  
Policy Owner's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
\_\_\_\_\_



**Mother's Information**

Step Mother  Guardian  
Name: \_\_\_\_\_  
Wk# \_\_\_\_\_ Hm# \_\_\_\_\_  
Employer: \_\_\_\_\_  
Job Title: \_\_\_\_\_  
SS# \_\_\_\_\_



**Secondary Orthodontic Insurance**

Orthodontic Coverage?  Yes  No  
Insurance Co. Name: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insurance Co. Phone #: \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy Owner's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Policy Owner's Birthdate: \_\_\_\_\_  
ID# \_\_\_\_\_  
Policy Owner's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
\_\_\_\_\_



**Father's Information**

Step Father  Guardian  
Name: \_\_\_\_\_  
Wk# \_\_\_\_\_ Hm# \_\_\_\_\_  
Employer: \_\_\_\_\_  
Job Title: \_\_\_\_\_  
SS# \_\_\_\_\_

CONTINUED ON BACK



**What are the main concerns that you would like orthodontics to accomplish?**

Has your child ever taken Phen-Fen?  Yes  No  
(Also known as Redux or Pondimin) If yes, when? \_\_\_\_\_

Has your child ever been evaluated or had orthodontic treatment before?  Yes  No

Have there been any injuries to the face, mouth, teeth or chin?  Yes  No

Have adenoids or tonsils been removed?  Yes  No

Has your child been informed of any missing or extra permanent teeth?  Yes  No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?  Yes  No

Does your child brush his/her teeth daily?  Yes  No

Floss his/her teeth daily?  Yes  No

Child's Physician: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Date of last Visit: \_\_\_\_\_

Is your child currently under the care of a physician?  Yes  No

Has puberty begun?  Yes  No

Has menstruation begun? (Girls)  Yes  No

Please describe your child's current physical health:  Good  Fair  Poor

Please list all drugs that your child is currently taking: \_\_\_\_\_

Please list all drugs/things that your child is allergic to: \_\_\_\_\_

Latex  Yes  No  
Metals/Nickels  Yes  No  
Plastics  Yes  No



**Neighbor/Relative not living with you.**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_



I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform necessary dental services my child may need.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_  
Comments: \_\_\_\_\_



**Has your child ever had any of the following medical problems?**

- Y N Abnormal Bleeding
- Y N ADD/ADHD
- Y N Allergies to any Drugs
- Y N Allergic to Latex/Metals
- Y N Any Hospital Stays
- Y N Any Operations
- Y N Artificial Bones/Joints/Valves
- Y N Asthma
- Y N Cancer
- Y N Congenital Heart Defect
- Y N Convulsions/Epilepsy
- Y N Diabetes
- Y N Handicaps/Disabilities
- Y N Hearing Impairment
- Y N Heart Murmur
- Y N Hemophilia
- Y N Hepatitis
- Y N HIV+/AIDS
- Y N Kidney/Liver Problems
- Y N Lupus
- Y N Rheumatic/Scarlet Fever
- Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



**Has your child ever experienced any of the following?**

- Y N Clenching/Grinding Teeth
- Y N Lip Sucking/Biting
- Y N Mouth Breather
- Y N Nail Biting
- Y N Nursing Bottle Habits
- Y N Speech Problems
- Y N Thumb/Finger Sucking