WELCOME TO

UNIVERSITY ORTHODONTICS

Please fill out this form completely; it is important to your child's orthodontic care. Our goal is to help your child reach and maintain good oral health and a beautiful smile that lasts a lifetime.

Today's Date:_____

Tell Us About Your Child:

Child's Name:_____
LAST FIRST MI

Nickname:_____ ☐M ☐F

Birthdate:___/____/___Age:_____SS #:_____
School:_____Grade:_____
Hobbies/Sports:_____ _____
Child's Home # (_____)_____
Child's Home Address:_____
_____
E-mail Address:_____

Who is Accompanying Your Child Today?

Name:_____Relation:_____
Do you have legal custody of this child? ☐Yes ☐ No
Whom may we thank for referring you?_____
List other family members seen by us_____
_____
General Dentist:_____
Date of last cleaning/visit:_____
Parent's Marital Status:

Parental Information:

☐Mother ☐Stepmother☐Guardian☐other_____
Name: _____Birthdate:___/___/___
Wk #: (___)_____Hm # (___)_____
Employer:_____
How long at current job:___ Job Title:_____
SS #:_____
☐Father ☐Stepfather☐Guardian☐other_____
Name: _____Birthdate:___/___/___
Wk #: (___)_____Hm # (___)_____
Employer:_____
How long at current job:___ Job Title:_____
SS #:_____

In the event of an emergency, whom should we contact?
His/Her Name:_____
Relationship:_____
Wk #: (___)_____Hm # (___)_____

Person Responsible for Account:

Name:_____Relation:_____
Billing Address:_____
_____
CITY STATE ZIP
Wk #: (___)_____Hm # (___)_____
Employer:_____
How long at current job:___ Job Title:_____
SS #:_____Birthdate:___/___/____

Who is responsible for making appointments?
Name:_____
Wk #: (___)_____Hm # (___)_____

Primary Orthodontic Insurance

Orthodontic Coverage? ☐yes ☐no
Insurance Co. Name:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #: (____)_____
Group # (plan, local or policy #):_____
Policy Owner's Name:_____
Relationship to patient:_____
Policy Owner's Birthdate: ____/____/_____
Policy Owner's ID #:_____
Policy Owner's Employer:_____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐yes ☐no
Insurance Co. Name:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #: (____)_____
Group # (plan, local or policy #):_____
Policy Owner's Name:_____
Relationship to patient:_____
Policy Owner's Birthdate: ____/____/_____
Policy Owner's ID #:_____
Policy Owner's Employer:_____

Records to be taken at the Initial Exam include photos, panoramic and cephalometric x-rays. These Records are provided at no cost, for use in our office, to aid Dr. Ogata with his comprehensive evaluation.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

Child's Medical/Dental History

What would you like orthodontics to accomplish?_____
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 (if yes, please circle which one)
Have adenoids or tonsils been removed? □YES □ NO (if yes, please circle which one)
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
Has your child had any speech problems? □YES □ NO
Does your child breathe through their mouth? □While awake □ While asleep
Is your child under the care of a physician? □YES □ NO
Child's Physician:_____ Phone # (____)_____ Date of last visit:_____
Please describe your child's current physical health: □Good □ Fair □ Poor
Are the child's immunizations current? □YES □ NO
Has puberty begun? □YES □ NO
Girls- Has menstruation begun? □YES □ NO (if yes, when:_____)
Please list all drugs that your child is currently taking and why: _____
_____
_____
Please list all drugs/things that your child is allergic to:
_____
Allergic to the following: Latex □YES □ NO Metals/Nickel □YES □ NO Plastics □YES □ NO
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 Allergic to Plastic
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Bones/ Joints
Y N Artificial 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 Nail Biting
Y N Nursing/Bottle Habits
Y N Thumb/Finger Sucking
Y N Tongue Thrust

Do they like their smile? □YES □ NO
If not, what would you change? _____
Would you like to discuss anything with the Doctor in private? □ YES □ NO

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 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 the necessary dental services that my child may need.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

If this office accepts insurance, 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

OFFICE USE ONLY

Doctor's
Comments:_____
_____
_____
_____