Andy Bennion DMD, MS, PC

SPECIALIST IN ORTHODONTICS

Innovative, patient-focused care for radiant smiles

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Member American Association of **Orthodontists**

Child History

Today's Date: ______________

We would like to welcome you and your child to our office. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below:

Child's Name: ______________________ (LAST / FIRST / MI) Goes By: ______________

❒ Male ❒ Female Child's Birthdate: ___/___/___ Child's Age: ______ Email: ______________

Child's Home Address: ______________________ (APT / CONDO # / CITY / STATE / ZIP)

Home #: ______________ Cell #: ______________

School: ______________________ Grade: ________

Who is accompanying your child today? Name: ______________________

Do you have legal custody of this child? ❒ Yes ❒ No

Whom may we thank for referring you to our office? ______________________

List brothers / sisters with age: ______________________

General Dentist: ______________________ Last Visit Date: ___/___/___

Parent's Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Mother's Information: ❒ Mother ❒ Stepmother ❒ Guardian

Name: ______________________ Birthdate: ___/___/___

Address: ______________________

Employer: ______________ Wk #: ______________ Ext: ______

How long at current job: ______________ Job Title: ______________

Home #: ______________ Cell #: ______________ Email: ______________

Father's Information: ❒ Father ❒ Stepfather ❒ Guardian

Name: ______________________ Birthdate: ___/___/___

Address: ______________________

Employer: ______________ Wk #: ______________ Ext: ______

How long at current job: ______________ Job Title: ______________

Home #: ______________ Cell #: ______________ Email: ______________

Person Responsible for the Account: Name: ______________ SS #: ______________

Additional Billing Address: ______________________

Employer: ______________ Wk #: ______________ Ext: ______

Relation: ______________________

Home #: ______________ Cell #: ______________ Email: ______________

Orthodontic Insurance

(CONTINUED ON BACK)

Name of Insurance Company: ______________________ Phone: ______________

Insurance Claims Address: ______________________

Subscriber ID #: ______________ Group #: ______________

Subscriber Name: ______________________ Subscriber DOB: ___/___/___

Employer Name: ______________________

Your child's attitude towards treatment: ❒ Eager ❒ Neutral ❒ Negative

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

____

Has your child ever been evaluated for or had orthodontic treatment before? ❒ Yes ❒ No If Yes, Which Dr.? ____________

Are you aware that patient cooperation is the main factor in length of orthodontic treatment and quality of results? ❒ Yes ❒ No

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

Have adenoids or tonsils been removed? ❒ Yes ❒ No

Does your child need pre-medication prior to dental visits? ❒ Yes ❒ No

Child's Height: ____________ Mother's Height ____________ Father's Height ____________

Has your child ever had any of the following medical problems? (Please check all that apply)

Please discuss any medical problems that your child has had: ____________________

______ Abnormal Bleeding	______ Hearing Impairment	______ Clenching / Grinding Teeth
______ Allergies to any Drugs	______ Heart Murmur	______ Lip Sucking / Biting
______ Allergic to any Drugs	______ Hepatitis	______ Mouth Breather
______ Asthma	______ HIV+/ Aids	______ Nail Biter
______ Cancer	______ Kidney / Liver Problems	______ Speech Problems
______ Congenital Heart Defect	______ Rheumatic / Scarlet Fever	______ Thumb / Finger Sucking
______ Convulsions / Epilepsy	______ Tuberculosis (TB)	______ Tongue Thrust
______ Diabetes		

Child's Physician: ____________________ Phone #: ____________

Date of last visit: ____ / ____ / ____ Is your child currently under the care of a physician? ❒ Yes ❒ No

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

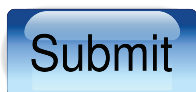
Please list all drugs your child is currently taking: ____________________

____

Please list all drugs your child is allergic to: ____________________

____

- This office reserves the right to verify credit status of person responsible for the account and/or potential patients or parents of patients prior to extending credit for treatment fees.
- I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.



____________________ / /

SIGNATURE DATE

Our mission is to be recognized and respected for providing the highest quality orthodontic care with unrivaled customer oriented service.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA,the CDC and the ADA.

Office Use

Findings: ____________________

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____

Recommendations: ____________________

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