

About Your Child

Please circle or check the appropriate areas.

Today's Date: _____

- Male
- Female

Child's Name: _____

LAST FIRST MI

Nickname: _____

SS#: _____

Child's Birth Date: ____/____/____

Child's Age: _____

School: _____

Grade: _____

Hobbies/Sports: _____

Child's Primary#: _____

Home/Cell/Business

Child's Home Address: _____

APT#

CITY STATE ZIP

General Dentist: _____

Address: _____

CITY STATE ZIP

Phone#: _____

Last Visit Date: _____

List brothers/sisters and ages: _____

Whom may we thank for referring you? _____

Mother's Information Step Mother Guardian

Name: _____

Birth Date: ____/____/____

Primary Phone#: _____

Home/Cell/Business

Secondary Phone#: _____

Home/Cell/Business

Employer: _____

SS#: _____

Email: _____

Father's Information Step Father Guardian

Name: _____

Birth Date: ____/____/____

Primary Phone#: _____

Home/Cell/Business

Secondary Phone#: _____

Home/Cell/Business

Employer: _____

SS#: _____

Email: _____

Parents' Marital Statuses:

- Single
- Married
- Widowed
- Divorced
- Separated

Who is accompanying your child today? _____

Relationship to child? _____

Do you have legal custody of this child? _____

Person(s) Responsible for Account

Name: _____ %

Relationship: _____

Address: _____

CITY STATE ZIP

Primary Phone#: _____

Home/Cell/Business

Name: _____ %

Relationship: _____

Address: _____

CITY STATE ZIP

Primary Phone#: _____

Home/Cell/Business

Primary Orthodontic Insurance

Orthodontic coverage? Yes No

Insurance Company Name: _____

Insurance Company Address: _____

CITY STATE ZIP

Insurance Company Phone #: _____

Policy Holder/Subscriber ID (SSN or ID#): _____

Plan/Group Number: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: ____/____/____

Policy Owner's SS#: _____

Policy Owner's Employer: _____

Secondary Orthodontic Insurance

Orthodontic coverage? Yes No

Insurance Company Name: _____

Insurance Company Address: _____

CITY STATE ZIP

Insurance Company Phone #: _____

Policy Holder/Subscriber ID (SSN or ID#): _____

Plan/Group Number: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: ____/____/____

Policy Owner's SS#: _____

Policy Owner's Employer: _____

What are the main concerns that you would like Orthodontics to address?

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

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

List any musical instruments played: _____

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra 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 N/A

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:

Does/Did your child have any of the following habits?

- [Y] [N] Clenching/ Grinding
- [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
- [Y] [N] Tongue Thrust

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

- [Y] [N] Abnormal Bleeding
- [Y] [N] Allergy to any Drugs
- [Y] [N] Allergy to Latex/ Metals
- [Y] [N] Allergy to Plastic
- [Y] [N] Any Hospital Stays
- [Y] [N] Any Operations
- [Y] [N] Asthma
- [Y] [N] Cancer
- [Y] [N] Congenital Heart Defect
- [Y] [N] Convulsions/ Epilepsy
- [Y] [N] ADD/ ADHD
- [Y] [N] Diabetes
- [Y] [N] Handicaps/ Disabilities
- [Y] [N] Hearing Impaired
- [Y] [N] Heart Murmur
- [Y] [N] Hemophilia
- [Y] [N] Hepatitis
- [Y] [N] HIV+/ AIDS
- [Y] [N] Kidney/ Liver Problems
- [Y] [N] Rheumatic/ Scarlet Fever
- [Y] [N] Tuberculosis (TB)

Please Discuss any medical problems that your child has had: _____

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 confidences 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 any necessary services my child may need.

The parent or Guardian who accompanies the child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Signature

Date

Voice Message Communication

- I authorize your office to leave voice messages for me on my home phone revealing the identity of your office. I also authorize you to leave voice messages concerning appointments, scheduling, and request for call back without mentioning specifics. I will accept responsibility for the privacy issues that may arise.*

- I do not authorize you to leave any voice messages for me from the office.*

Signature: _____

Date: _____

Agreement to Receive Electronic Communication

Marble Hill Orthodontics – Dr. Ryan Walter, D.M.D., LLC

Patient Name: _____

Date of Birth: _____

I agree that the Marble Hill Orthodontics – Dr. Ryan Walter, D.M.D. may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

*I can withdraw my consent to electronic communications by calling:
(908) 859-4555*

Email Address (PLEASE PRINT CLEARLY):

Signature: _____

Date: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Marble Hill Orthodontics to furnish information to insurance carriers concerning my treatment. I understand that I am responsible for any amount not covered by insurance.

Signature of Parent or Guardian

Date

Signature

Date

Acknowledgement of Receipt of Notice of Privacy Practices

Marble Hill Orthodontics – Dr. Ryan Walter, D.M.D., LLC

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign*
- Communications barriers prohibited obtaining the acknowledgement*
- An emergency situation prevented us from obtaining acknowledgement*
- Other (Please Specify)*

