



**SMILE ART ORTHODONTICS**  
New Patient Information (MINOR PATIENT)

Welcome! Please assist us in your child's treatment by filling this form out accurately and completely. Thank you.

Today's Date: \_\_\_\_\_

Patient's Name (Last, First, MI): \_\_\_\_\_ Prefers to be called: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Home address: \_\_\_\_\_

Home phone #: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies / Sports / Musical inst.: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

(For the parent information following, write "same" in applicable areas if information is same as patient's information above)

**Parent information #1**

Please select:  Mother  Father  Step-mother  Step-father  Guardian

Name (Last, First, MI): \_\_\_\_\_ Gender:  Male  Female

Home address: \_\_\_\_\_

Tel #: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status:  Single  Married  Other

If married, spouse's name: \_\_\_\_\_

**Parent information #2**

Please select:  Mother  Father  Step-mother  Step-father  Guardian

Name (Last, First, MI): \_\_\_\_\_ Gender:  Male  Female

Home address: \_\_\_\_\_

Tel #: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status:  Single  Married  Other

If married, spouse's name: \_\_\_\_\_

Who is financially responsible for the account?: \_\_\_\_\_

Who should be contacted for scheduling/confirming?: \_\_\_\_\_

Patient's Name (Last, First, MI): \_\_\_\_\_

### Medical History

Physician's Name, City and State: \_\_\_\_\_

Phone #: \_\_\_\_\_ Approximate Date of last visit: \_\_\_\_\_

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

If yes, please explain: \_\_\_\_\_

Is child taking any prescription/over-the-counter drugs?  Yes  No

If yes, please specify and explain reason: \_\_\_\_\_

Does child have a history of any major illness/hospitalization?  Yes  No

If yes, please explain: \_\_\_\_\_

Does child use any tobacco products?  Yes  No If yes, what and how often? \_\_\_\_\_

**Does child have / has ever had / been treated for any of the following? Please select all that apply:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Abnormal bleeding                     | <input type="checkbox"/> Eating disorder               | <input type="checkbox"/> Latex allergy              |
| <input type="checkbox"/> Anemia                                | <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> Liver problems             |
| <input type="checkbox"/> Arthritis                             | <input type="checkbox"/> Epilepsy/seizures/convulsions | <input type="checkbox"/> Osteoporosis               |
| <input type="checkbox"/> Artificial joints                     | <input type="checkbox"/> Fainting/dizziness            | <input type="checkbox"/> Psychiatric problems       |
| <input type="checkbox"/> Artificial heart valves               | <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Radiation treatment        |
| <input type="checkbox"/> Asthma                                | <input type="checkbox"/> Hearing loss/impairment       | <input type="checkbox"/> Rheumatic/Scarlet fever    |
| <input type="checkbox"/> Auto-immune disease                   | <input type="checkbox"/> Heart attack/stroke           | <input type="checkbox"/> Severe/frequent headaches  |
| <input type="checkbox"/> Blood disorders                       | <input type="checkbox"/> Heart murmur                  | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Cancer/chemotherapy                   | <input type="checkbox"/> Heart surgery/pacemaker       | <input type="checkbox"/> Sickle cell disease/traits |
| <input type="checkbox"/> Canker sores/oral aphthous ulcers     | <input type="checkbox"/> Hemophilia                    | <input type="checkbox"/> Sinus problems             |
| <input type="checkbox"/> Cold sores/fever blisters/oral herpes | <input type="checkbox"/> Hepatitis                     | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Congenital heart defect               | <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> Venereal disease           |
| <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> HIV+/Aids                     | <input type="checkbox"/> Ulcers/Colitis             |
| <input type="checkbox"/> Difficulty breathing                  | <input type="checkbox"/> Hospitalized for any reason   |   |
| <input type="checkbox"/> Drug/alcohol abuse                    | <input type="checkbox"/> Kidney problems               |   |

Details: \_\_\_\_\_

Please list any drugs/materials that child is allergic to: \_\_\_\_\_

Patient's Name (Last, First, MI): \_\_\_\_\_

### Dental History

Name of child's dentist: \_\_\_\_\_ Approximate date of last visit: \_\_\_\_\_

Chief concern: \_\_\_\_\_

**Please check applicable boxes, and enter any relevant details below:**

- Has child ever had or been evaluated for orthodontic treatment?  Yes  No
- Has child ever had a serious/difficult problem with any previous dental work?  Yes  No
- Does child have or has ever had pain/discomfort in the jaw joint (TMJ/TMD)?  Yes  No
- Has child ever had injury to (check all applicable):  Mouth  Teeth  Chin  Face
- Does child have any speech problems?  Yes  No
- Does child generally breathe through the mouth?  Yes  No
- If yes, please select applicable:  While awake  While asleep
- Does child have habit of thumb/finger sucking?:  Yes  No
- Have you ever been told that your child has tongue thrust?:  Yes  No
- Does child clench/grind teeth?  Yes  No
- Does child have any missing or extra permanent teeth to your knowledge?  Yes  No

Details: \_\_\_\_\_

I understand that the information that 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 child's medical and/or dental health status.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to child

Patient's Name (Last, First, MI): \_\_\_\_\_

### INSURANCE INFORMATION

Please take care in filling out the required insurance information accurately in order to facilitate efficient billing and claims processing. If you have an insurance card, please bring it with you for the first visit. Thanks!

#### Primary Insurance

Orthodontic Coverage:  Yes  No  Don't know      Dental Coverage:  Yes  No  Don't know

Subscriber's name: \_\_\_\_\_ Subscriber's birthdate: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance co. name: \_\_\_\_\_

Insurance co. phone #: \_\_\_\_\_

Subscriber's SS#: \_\_\_\_\_ ID# / Policy#: \_\_\_\_\_

#### Secondary Insurance

Orthodontic Coverage:  Yes  No  Don't know      Dental Coverage:  Yes  No  Don't know

Subscriber's name: \_\_\_\_\_ Subscriber's birthdate: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance co. name: \_\_\_\_\_

Insurance co. phone #: \_\_\_\_\_

Subscriber's SS#: \_\_\_\_\_ ID# / Policy #: \_\_\_\_\_

I hereby authorize payment of orthodontic benefits otherwise payable to me, directly to the office of Dr. Monica Teredesai. I understand that it is my responsibility to inform this office if there are any changes in my insurance information/coverage.

\_\_\_\_\_  
Subscriber's Signature

\_\_\_\_\_  
Date

#### **For Office Use Only**

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