Waugh+allen orthodontics

We look forward to seeing you:
_____ at _____am / pm
We would appreciate you arriving 10 minutes before the appt time with this form completed.

Today's Date: _____

CHILD FORM

Please take this time to tell us about your child.

Name:_____
First Middle Last
Child prefers to be called _____ ❑Male ❑Female
Nickname
Child's Birth Date:_____/_____/_____ Age:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone:(_____) _____
Family E-Mail Address: _____
School:_____ Grade:_____
Hobbies/Sports:_____
Musical instruments: _____

WHO'S ACCOMPANYING THE CHILD TODAY?

Name:_____ Relation: _____
Do you have legal custody of the child? ❑Yes ❑No
Are there any other family members being seen by Dr. Waugh at this time?
What are their names: _____
Please give names and ages of any other children in the family:
_____
_____
Parental Marital Status:
❑Single ❑Married ❑Widowed ❑Divorced ❑Separated

MOTHER'S INFO: ❑Mother ❑Step-Mother ❑Guardian

Name:_____ Birth Date:_____/_____/_____
Address (if different from child's): _____
City:_____ State:_____ Zip:_____
Work:(_____) _____ Cell:(_____) _____
Employer: _____
Occupation :_____
How long: _____

FATHER'S INFO: ❑Father ❑Step-Father ❑Guardian

Name:_____ Birth Date:_____/_____/_____
Address (if different from child's): _____
City:_____ State:_____ Zip:_____
Work:(_____) _____ Cell:(_____) _____
Employer: _____
Occupation:_____
How long: _____

Who may we thank for referring you to our office?
_____

INSURANCE

Primary Dental Insurance

Employer: _____
Insurance Co. Name: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone:(_____) _____
Insured Name: _____
Relation to Patient:_____ Birth Date: _____/_____/_____
SS#:_____ Group #:_____

Secondary Dental Insurance

Employer: _____
Insurance Co. Name: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone:(_____) _____
Insured Name: _____
Relation to Patient:_____ Birth Date: _____/_____/_____
SS#:_____ Group #:_____
** I hereby authorize the release of any information relating to this claim
Signature_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____ Relationship_____
Address (if different)_____How long at address:_____
City:_____ State:_____ Zip:_____
Home:(_____) _____ Cell:(_____) _____
E-mail Address: _____
Emergency Contact: _____
Relation: _____ **Home:**(_____) _____

I understand that where appropriate Credit Bureau reports may be obtained.
Signature_____

GENERAL DENTIST

Name:_____Last Dental Exam_____
Were you referred by your dentist: ❑Yes ❑No

MEDICAL HISTORY

A complete history is vital for a proper orthodontic evaluation.

Child's Physician: _____

Phone No:_____

Is he/she taking any prescription medication: ❑ Yes ❑ No

If yes, please list which one(s): _____

_____

Please Circle all that apply:

- **Abnormal Bleeding**
- **ADD / ADHD**
- **AIDS or HIV positive**
- **Artificial Bones / Joints**
- **Asthma**
- **Birth Defects**
- **Blood Pressure-High or Low**
- **Bone Fractures**
- **Cancer or Tumors**
- **Chest Pain**
- **Congenital Heart Defect**
- **Convulsions**
- **Diabetes**
- **Ear, Nose or Throat**
- **Endocrine or Thyroid**
- **Epilepsy**
- **Excessive Weight Loss/Gain**
- **Fainting Spells, Seizures**
- **Handicap / Disabilities**
- **Hay Fever or Sinus Trouble**
- **Hearing Impairment**
- **Heart Trouble / Murmur**
- **Hepatitis**
- **Immune System**
- **Jaundice or Liver Problems**
- **Kidney Problems**
- **Mental Health / Behavioral**
- **Mitral Valve Prolapse**
- **Neurological Problems**
- **Nose or Throat**
- **Pneumonia**
- **Polio, Mono or Tuberculosis**
- **Prosthetics**
- **Rheumatic or Scarlet Fever**
- **Rheumatoid / Arthritic**
- **Sickle Cell Disease / Traits**
- **Skin Disorders**
- **Speech Difficulties**
- **Stomach Ulcers/Hyperacidity**
- **Swelling Ankles**
- **Vision Difficulties**

Are your child's immunizations current? ❑ Yes ❑ No

Any Hospital Stays / Operations? _____

_____

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

MEDICAL ALERT INFORMATION

Does he / she normally require antibiotic pre-medication prior to dental procedures? ❑ Yes ❑ No _____

Is he / she allergic to any of the following?

Latex	❑ Yes ❑ No	Plastic	❑ Yes ❑ No
Nickel	❑ Yes ❑ No	Aspirin	❑ Yes ❑ No
Erythromycin	❑ Yes ❑ No	Codeine	❑ Yes ❑ No

List any other allergies: _____

DENTAL HISTORY

Has your child ever been evaluated by an Orthodontist? ❑ Yes ❑ No

If so, by whom?_____

Has your child ever had orthodontic treatment? ❑ Yes ❑ No

If so, by whom? _____

Were you happy with the results? ❑ Yes ❑ No

Have other members of the family had orthodontic treatment?

❑ Yes ❑ No Were you happy with the results? ❑ Yes ❑ No

By whom (if other than Dr. Waugh)?_____

What are your main concerns that you would like orthodontics to correct? _____

_____

Does your child experience any pain, clicking or discomfort in or near the ears? ❑ Yes ❑ No

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

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

Have you been informed of missing or extra permanent teeth? ❑ Yes ❑ No

Are you aware of any gum problems? ❑ Yes ❑ No

Have their tonsils or adenoids been removed? ❑ Yes ❑ No

Does/did your child have any of the follow habits? (Please circle)

- Clenching / Grinding Teeth
- Lip Sucking / Biting
- Mouth Breather
- Nail Biting
- Pacifier User (Until: _____ age)
- Thumb / Finger Sucker (Until: _____ age)

Will the patient comply with wearing their braces or orthodontic appliances? ❑ Yes ❑ No

I hereby certify that I have reviewed the above medical and dental history and agree that it is, to the best of my knowledge, accurate at this time. If there are any future changes in this information I will inform the practice of these changes.

_____ _____

Parent / Guardian Signature **Date**