WELCOME TO BOSS ORTHODONTICS!

Young Person's Orthodontic Information

Date:__________________

Name:_________________________ I prefer to be called:____________ Gender:__________

Address:__________________________________City:_________________St:_____Zip:__________

Home #:_______________________Cell#:_____________________

D.O.B_______________ General Dentist___________________ E-Mail:__________________

Who is accompanying this young person today?

Name: ____________________________ Relation:_________________________

How did you hear of our office? __________________________________

Parent's Marital Status (please circle): Married Divorced Single Widowed

Mother's Information (please circle): Natural Step Guardian Adopted

Name:_______________________ Home#_________________ Cell #________________

Address:____________________________City:________________St.________Zip:_______

Employer:________________________ Work# _________________________

Soc.Sec. #_____________________ D.O.B._________

Father's Information (please circle): Natural Step Guardian Adopted

Name:_______________________ Home# _________________ Cell#___________________

Address:____________________________City:________________St.________Zip:_______

Employer_________________________ Work#__________________________

Soc.Sec. #___________________ D.O.B.___________

Person Responsible for Account:

Name:______________________________________Relation:__________________________

Home# _________________ Cell#___________________

Billing Address:________________________City:________________ St.:______ Zip:________

Employer: _________________________________ Work #_____________________

Soc Sec # _________________ D.O.B.______________E-Mail:____________________________

Primary Orthodontic Insurance

Insurance Company Name:____

Insurance Company Address:____

Insurance Company Phone #:____

Insured's Name: ______________________________ Relationship to Patient:_______________

Group/Policy#:_________________________ Insured's D.O.B.______________________

Insurance ID#:_________ ____________ Insured's Employer:____________________________

Secondary Orthodontic Insurance

Insurance Company Name:____

Insurance Company Address:____

Insurance Company Phone#:____

Insured's Name: ________________________ Relationship to Patient:__________________

Group/Policy#______________________ Insured's D.O.B:_______________________

Insurance ID#_______________________ Insured's Employer:_________________________

Has your child ever been evaluated for orthodontic treatment before?_____Yes______No
What was done? ______________________________________
Have there been any injuries to the face, mouth, teeth, or chin? _______Yes _______No
Explain: _____________________________________
Have adenoids been removed? ___ Yes ____ No, have tonsils been removed? ____Yes ____No
Have you been informed of any missing or extra permanent teeth? _______Yes ________No
Has your child ever had pain / tenderness in the jaw joint?_______ Yes ______No
Does your child brush his / her teeth daily?_____Yes _____No How many times?__________
Child's Physician________________________ Is you child currently under the care of a Physician?
_____ Yes ______No, if yes for what reason?____
Please list all drugs your child is currently taking:_______________________________________

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

Y N Allergic to Plastics	Y N Allergic to Latex/ Metals
Y N Heart Murmur	Y N Congenital Heart Defect
Y N Cancer	Y N Convulsions / Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheumatic Fever	Y N Hearing Impairment
Y N HIV+ / AIDS	Y N Any Operations
Y N Hemophilia	Y N Any Stays in a Hospital
Y N Asthma	Y N Kidney / Liver Problems
Y N Hepatitis	Y N Handicaps / Disabilities
Y N Tuberculosis (TB)	Y N Allergic to any Drugs______________ Which ones?

Does your child have any of the following habits?

Y N Thumb / Finger Sucking	Y N Mouth Breather
Y N Speech Problems	Y N Clenching / Grinding Teeth
Y N Tongue Thrust	Y N Nail Biting

I understand that the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my child's medical status.

____________________________________ ______________________

Signature of Parent or Guardian Date

Date: _________ Age:____________
Malocclusion: Class ____ Rt____Lft **Overjet**________**Overbite**________
Maxillary spacing: slt mod svr **Mandibular spacing**: slt mod svr
Maxillary crowding: slt mod svr **Mandibular crowding**: slt mod svr
Constriction: max mand
Crossbites: __________________
Notes:____