

PATIENT INFORMATION

Date _____

Name: _____ Home Phone #: _____
First Middle Last Nickname
 Address: _____ Email: _____ Birthday: _____
 City: _____ State: _____ Zip: _____ Age: _____ Sex: M F
 Referred By: _____ School: _____ Grade: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Who does child reside with? ___ Mom ___ Dad ___ Both ___ Other _____
 Parent's Marital Status: ___ Single ___ Widowed ___ Married ___ Divorced ___ Separated

PARENTS INFORMATION

FATHER Step Guardian

MOTHER Step Guardian

Name: _____
 Father's Address Same As Child's: yes no
 Other Address: _____
 Home #: _____ Work #: _____
 Employer: _____ Cell: _____
 Email: _____

Name: _____
 Mother's Address Same As Child's: yes no
 Other Address: _____
 Home #: _____ Work #: _____
 Employer: _____ Cell: _____
 Email: _____

MEDICAL INFORMATION

Child's Physician: _____ Phone #: _____ Date of Last Visit: _____

	YES	NO		YES	NO
Is Patient Under the Care of a Physician:	_____	_____	Handicaps/Disabilities/Hearing Impairment:	_____	_____
Is the Patient in Good Health:	_____	_____	Diabetes:	_____	_____
ADD/ADHD:	_____	_____	Asthma or Hay Fever:	_____	_____
Any Hospital Stays/Operations:	_____	_____	Tuberculosis:	_____	_____
Any Heart Disease/Defects:	_____	_____	Abnormal Bleeding:	_____	_____
H.I.V. Positive/AIDS:	_____	_____	Any Seizure Disorder:	_____	_____
Artificial Bones, Joints/Valves:	_____	_____	Lupus:	_____	_____
Cancer:	_____	_____	Kidney Problems:	_____	_____
Any High or Low Blood Pressure:	_____	_____	Rheumatic Fever/Scarlet Fever:	_____	_____
A History of Fainting or Dizziness:	_____	_____	Allergic to Latex / Metals:	_____	_____
Heart Murmur:	_____	_____	Has puberty begun:	_____	_____
Hemophilia:	_____	_____	Has menstruation begun? (Girls):	_____	_____
Hepatitis/Liver Problems:	_____	_____	Patient ever taken Phen-Fen?(aka Redux or Pondium):	_____	_____
Sickle Cell Disease/Traits:	_____	_____	If yes, when?	_____	_____

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

List Any Medications Currently Taking: _____

Is the Patient Allergic to Anything, if so what: _____

Any other disease, condition, or problem not listed above that we should know about: _____

DENTAL HISTORY

Child's Dentist: _____ Phone #: _____ Date of Last Visit: _____

	YES	NO		YES	NO
Has the Patient Been Evaluated or had Orthodontic Treatment Before:	_____	_____	Thumb/Finger Sucking:	_____	_____
Has the Patient Seen a General Dentist in the Last Year:	_____	_____	Mouth Breather:	_____	_____
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:	_____	_____	Finger Nail Biting:	_____	_____
Frequent Headaches:	_____	_____	Tongue Thrusting:	_____	_____
Are You Aware of Any "Gum" Problems:	_____	_____	Clench/Grind Teeth:	_____	_____
Have the Patient's Tonsils or Adenoids Been Removed:	_____	_____	Speech Problems:	_____	_____
Know of Any Missing or Extra Permanent Teeth:	_____	_____	Nursing/Bottle:	_____	_____
Pain/Clicking/Popping in Jaw Joint (TMD/ TMJ):	_____	_____	Brush Twice a Day:	_____	_____

Floss: Every Day Some Days Never

In Your Own Words What is the Orthodontic Problem: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
 Billing Address: _____

 City State Zip
 Home Address if different: _____

 Home/ Cell #: _____ DL #: _____
 Employer: _____ Wk #: _____
 SS#: _____ Birthdate: _____

PRIMARY INSURANCE

Dental Coverage? Yes No Ortho Coverage? Yes No
 Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co. Phone #: _____ Group/ Policy #: _____
 Policy Owner's Name: _____ Relation to Patient: _____
 Policy Owner's Birth Date: ___/___/___ ID or SS#: _____
 Policy Owner's Employer: _____

SECONDARY INSURANCE

Dental Coverage? Yes No Ortho Coverage? Yes No
 Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co. Phone #: _____ Group/ Policy #: _____
 Policy Owner's Name: _____ Relation to Patient: _____
 Policy Owner's Birth Date: ___/___/___ ID or SS#: _____
 Policy Owner's Employer: _____

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 confidence 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 the necessary dental services my child may need.

 Signature of parent or guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

 Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.

This office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

****** Please note that some longer procedures are only done in the mornings during school hours ******

Ryan Boyer Orthodontist • (951) 600-7923 • 40680 California Oaks Rd Ste 1B, Murrieta, CA 92562 • www.boyerortho.com

