ABOUT YOUR TEEN

Teen's Name: ______________________________
LAST FIRST MI

Teen's nickname: ________________ ❑ Boy ❑ Girl

Teen's Birthdate: ____/____/______ Age: _____

School: ________________________ Grade: _____

Teen's Home Phone #: (____) ________--__________

Teen's SS# ________--______--________

Teen's Address: ______________________________

____
CITY STATE ZIP

Referred by: ______________________________
(If doctor, please give address and phone #.)

____

INSURANCE INFORMATION

Primary Dental Insurance

Co. Name: ______________________________

Address: ______________________________

____
CITY STATE ZIP

Phone #: ( ) ____________--______________

Insured's ID#: ______________________________

Group # (Plan, Local, or Policy #): ________________

Insured's Name: ______________________________

Relation: ______________ Date of Birth: __/___/___

Insured's Employer:

____

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: ______________________________

Address: ______________________________

____
CITY STATE ZIP

Phone #: ( ) ____________--______________

Insured's ID#: ______________________________

Group # (Plan, Local, or Policy #): ________________

Insured's Name: ______________________________

Relation: ______________ Date of Birth: __/___/___

Insured's Employer: ______________________________

TEEN'S FAMILY INFORMATION

Who is accompanying this teen today?

______________________________ ______________
FULL NAME (IF OTHER THAN PARENT) RELATION TO TEEN

Do you have Legal Custody of this Teen? ❑ Yes ❑ No

How many Brothers/Sisters? ____ Age(s)? ________

Mother's Name: ______________________________

❑ STEPMOTHER ❑ GUARDIAN

____
(❑CHECK IF SAME AS TEEN'S) HOME ADDRESS CITY STATE ZIP

(____)_____--_______ (____)_____--_______ Ext. ____
HOME PHONE # WORK PHONE #

____-____-_____ ____/____/_____ ______________
MOTHER'S SS# DATE OF BIRTH MOTHER'S DRIVERS Lic. #

Employer: ______________________ How Long? ______

____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: ______________________________

❑ STEPFATHER ❑ GUARDIAN

____
(❑CHECK IF SAME AS TEEN'S) HOME ADDRESS CITY STATE ZIP

(____)_____--_______ (____)_____--_______ Ext. ____
HOME PHONE # WORK PHONE #

____-____-_____ ____/____/_____ ______________
FATHER'S SS# DATE OF BIRTH FATHER'S DRIVERS Lic. #

Employer: ______________________ How Long? ______

____
EMPLOYER'S ADDRESS CITY STATE ZIP

ACCOUNT INFORMATION

Person ultimately responsible for account

Name: ______________________ ______________
RELATION TO TEEN

Billing Address: ______________________________

____
CITY STATE ZIP

____-_____-_____ ____/____/_____ ______________
SOCIAL SECURITY# DATE OF BIRTH DRIVERS LICENSE #

(____)_____--_______ (____)_____--_______ Ext. ____
CELL PHONE # WORK PHONE #

Payment method: ❑ Cash ❑ Check

______________________________ ____/____
❑ Credit Card – Enter card # above (if accepted) Exp Date

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

____
Initials

TEEN'S DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Teen in pain? ❑ No ❑ Yes How long? ____________________

Please indicate ❑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth

❑ Red, Swollen or bleeding gums. ❑ Teeth grinding ❑ Locking jaw

❑ Sensitive tooth, teeth or gums. ❑ Ringing in ears ❑ Bad Breath

❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth ❑ Loose tooth

❑ Other(s): ____________________

Does teen require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ____________________ (____) _____--_________

Last dental exam? ____/____/_____ Last dental x-rays? ____/____/_____

# of times a day teen brushes? _____ # of times a week teen flosses? _____

Is the teen's water fluoridated? ❑ Yes ❑ No

How would you rate the teen's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

TEEN'S MEDICAL HISTORY

Is Teen taking any of the following medications? ❑ Pain killers (including aspirin) ❑ Ritalin

❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle Relaxers

❑ Other(s):____________________

Teen's Physician:____________________ Physician's Phone #: (_____)______--_________

Physician's Address:____________________ Last Medical Exam: ___/___

ITY STATE ZIP

Does Teen have or ever had any of the following diseases, medical conditions or procedures?

❑ Heart Murmur	❑ Tonsillitis	❑ Chicken Pox
❑ Rheumatic fever	❑ Respiratory Problems	❑ Hepatitis
❑ Artificial Heart Valve	❑ Asthma/Difficulty Breathing	❑ Liver/Kidney/Organ Problems
❑ Congenital Heart defect	❑ Blood Transfusion(s)	❑ Artificial Bones/Joints/Implants
❑ Surgeries/Operations	❑ Leukemia/Anemia	❑ HIV+/AIDS/ARC
❑ Cancer/Tumors	❑ Diabetes/Hypoglycemia	❑ Tuberculosis TB
❑ Chemotherapy	❑ Hemophilia/Abnormal Bleeding	❑ Psychiatric Problems
❑ Jaw Problems TMJ/TMD	❑ Cleft Lip/Palate	❑ Hyper Active/ADD
❑ Hearing Problems	❑ Birth Defects	❑ Cerebral Palsy

Please list any other medical condition(s) teen has or ever had:____________________

Is Teen allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Food Allergies

❑ Dental Anesthetics (Novocaine) ❑Other(s):____________________

Please rate the teen's general health from 1-10:______ Does teen wear contact lenses? ❑ Yes ❑ No

Has this teen ever taken the drug Ritalin? ❑ No ❑ Yes/How Long?___________ Teen's Blood Type:_____

Does this teen do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking

❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

Signature ____________________ Date _____/_____/_______

❑ Parent or Guardian ❑ Other: