Alexandria Orthodontics
Welcome Form
Patients Under Age 18
CONFIDENTIAL

Tell Us About Your Child:

Today's Date:_____

Patient Name:_____ _____ **Birthdate :**_____
Last **First** **Middle Initial** **Preferred Name** **Age:**_____

Child's Home Address: _____ **Sex:** ☐ Male ☐ Female

City_____ **State**_____ **Zip:** _____
Home Phone (_____) _____ **Cell Phone (_____)** _____
Email Address:_____ **SSN:** _____
Whom may we thank for referring you?_____
In Case of an Emergency, who should we notify? _____ **Phone (____)**_____

Responsible Party:

Parent/Guardian
Custodial Parents Name(s):_____
Patient Lives with (check all that apply) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparents(s) ☐ Other _____
Is the Responsible Party with the Child Today? ☐ Yes ☐ No If Not, what is your relation to patient? _____

Mother's Full Name: _____ **Title:** ☐ Mrs ☐ Ms ☐ Dr ☐ Other _____
Address (if different from above): _____
Home # (_____) _____ **Cell # (_____)** _____ **Business # (_____)** _____
Email Address: _____ **Occupation:** _____

Father's Full Name: _____ **Title:** ☐ Mr ☐ Dr ☐ Other _____
Address (if different from above): _____
Home # (_____) _____ **Cell # (_____)** _____ **Business # (_____)** _____
Email Address: _____ **Occupation:** _____

Siblings: _____ **Age** _____ **Siblings:** _____ **Age** _____
Siblings: _____ **Age** _____ **Siblings:** _____ **Age** _____

Insurance:

Primary Insurance
Primary policy holder's full name _____**Birthdate:**_____
Social Security # _____ **Relationship to patient** _____
Address and phone (if not listed above) _____
Employer: _____ **Address:** _____
Insurance Company: _____ **Group # :**_____ **ID#:** _____
Does this policy have benefits? ☐Yes ☐No ☐ Don't Know

Secondary Insurance
Secondary policy holder's full name _____**Birthdate:**_____
Social Security # _____ **Relationship to patient** _____
Address and phone (if not listed above) _____
Employer: _____ **Address:** _____
Insurance Company: _____ **Group # :**_____ **ID#:** _____
Does this policy have benefits? ☐Yes ☐No ☐ Don't Know

Dental History

Why did you bring this child to the Orthodontist today?

_____

Has the child ever had a serious/difficult problem associated with dental work? ☐ Yes ☐No

Is the child's water fluoridated ☐ Yes ☐No

Is the child taking fluoridated supplements ☐ Yes ☐No

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD) ☐ Yes ☐No

Floss their teeth daily ☐ Yes ☐No

Does the Child have any of the following habits?

Y	N	
☐	☐	Thumb sucking/ Finger sucking
☐	☐	Lip sucking/ biting
☐	☐	Nail biting
☐	☐	Nursing bottle habits
☐	☐	Grinding/ Clenching
☐	☐	Other: _____

Health History:

Y	N		Y	N	
☐	☐	Heart Murmur	☐	☐	Congenital Heart Defect
☐	☐	Cancer	☐	☐	Convulsions/ Epilepsy
☐	☐	Rheumatic Fever	☐	☐	Abnormal Bleeding
☐	☐	HIV+/AIDS	☐	☐	Hearing Impairment
☐	☐	Hemophilia	☐	☐	Any Operations
☐	☐	Asthma	☐	☐	Any stays in Hospital
☐	☐	Hepatitis	☐	☐	Kidney/Liver Problems
☐	☐	Tuberculosis	☐	☐	Handicaps/Disabilities
☐	☐	Prosthesis	☐	☐	Allergies to Any drugs
☐	☐	Nickel Allergy	☐	☐	History of Scarlet Fever
☐	☐	Diabetes	☐	☐	Latex sensitivity/Allergies

Is the child currently under the care of a physician?

☐ Yes ☐No

Explain: _____

Child's Physician: _____

Please describe the child's health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs the child is currently taking: _____

_____

Please list all drugs the child is allergic to: _____

_____

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

Signature: _____ Date: _____

Office Use Only --- Office Use Only --- Office Use Only --- Office Use Only

I verbally review the medical / dental information above with the parent/ guardian & patient named herein.

Initials: _____ Date: _____

Doctor's comments: _____