MOUNTAIN VIEW ORTHODONTICS
F. RICHARD BECKWITH D.D.S. M.S. P.C.
Specialist in Orthodontics

UNDER 18

NAME_____ Prefers to be called _____ Sex___ Birth date____/____/____ Age____

Child's Hm. Address_____ City_____ Zip_____ Child's Hm. phone_____

E-mail (to confirm appts) _____ School_____ Grade_____

Favorite School Subjects_____ What is the quality of their school work? A__B__C__D__F__

Hobbies/Sports/Musical Instruments_____

Please list brothers/sisters with age: _____

Has anyone in the family had braces?_____ Who?_____ Were you/they pleased with the results?_____

Who is accompanying your child today?_____ Relation_____

Whom may we thank for referring you?_____ General Dentist_____

How often does your child see the dentist?_____ Date of last dental exam(MM/YY)_____/_____

What are the main concerns that you would like orthodontics to address? _____

Has your child been evaluated for orthodontic treatment previously? When?___/____Where?_____	Y	N
Is your child self-conscious of his/her teeth?	Y	N
Have there been any injuries to the face, mouth, teeth or chin?	Y	N
Please circle if: adenoids / tonsils / or both / have been removed? When? ____/____	Y	N
Have you been informed that he/she is missing or has extra permanent teeth?	Y	N
Has your child ever had any pain/tenderness in his/her jaw joint (TMJ)?	Y	N
Does your child have any dental problems at this time (pain, cavities, etc.)?	Y	N
Does your child have a fear of dentists?	Y	N
Does he/she have to be reminded to brush the teeth daily?	Y	N

Please explain any 'Y' answers above_____

Does your child have or have they had any of the following **habits or problems**?

Thumb, finger, or pacifier sucking	Y	N	Speech problems or tongue thrust	Y	N
Snoring / Mouth breathing	Y	N	Substance abuse problems	Y	N
Clenching/grinding	Y	N	Smoke or chew tobacco	Y	N

Please explain any 'Y' answers above_____

Is your child **allergic** to any of the following?

Penicillin	Y	N	Nickel or other metal	Y	N
Latex, vinyl, or acrylic	Y	N	Other allergies_____		

If any of your answers are 'Y', what happens when your child is exposed to the allergen?_____

MEDICAL INFORMATION **Child's Physician:**_____

Did/does your child you have?:

Ever have to be hospitalized	Y	N	Heart condition or heart problems	Y	N
Recurrent or chronic illness	Y	N	Hepatitis or liver problems	Y	N
Asthma or respiratory problems	Y	N	Thyroid or other hormone therapy	Y	N
Blood transfusion/AIDS/HIV virus	Y	N	Psychiatric counseling	Y	N
Bone fractures or major accident	Y	N	ADD/ADHD	Y	N
Cancer, radiation, or chemotherapy	Y	N	Sensory or Anxiety concerns	Y	N
Diabetes	Y	N	Frequent or severe headaches	Y	N
Epilepsy or seizures	Y	N	Lip or inside mouth lesions (sores)	Y	N

Please explain any 'Y' answers or list any health concerns not addressed above**:**_____

_____

Some medications can affect tooth movement. Please list any medications your child is taking and the condition for which the medication was prescribed:_____

Growth, maturation, and genetic tendencies play an important role in determining the most opportune time to begin orthodontic treatment. **We request the following information to assist in determining jaw and overall growth potential:**

Child's height :_____ Biological father's height:_____ Biological mother's height:_____

Has your child:(If male) had voice changes? **Y N When?**___/___ **(If female)** begun menstruation? **Y N When?**____/____

Child lives with: Both parents____ Mother____ Father____ Other_____

Mother's Name_____ **Biological □ Adoptive □ Stepmother □ Guardian □**

Address_____ Phone_____

Employer_____ Work Phone _____ Cell Phone _____

Father's Name_____ **Biological □ Adoptive □ Stepfather □ Guardian □**

Address_____ Phone_____

Employer_____ Work Phone_____ Cell Phone _____

Patient's biological parents: □ Married □ Divorced □ Mother remarried □ Father remarried □ Separated □ Widowed (N/A if patient adopted)

PERSON RESPONSIBLE FOR MAKING APPOINTMENTS: _____

WE WILL ASK WHOEVER IS GIVING CONSENT FOR ORTHODONTIC TREATMENT TO SIGN THE FINANCIAL AGREEMENT AND BE RESPONSIBLE FOR PAYMENT OF THE ACCOUNT. ANY ARRANGEMENTS FOR A THIRD PARTY PAYMENT WILL BE AN AGREEMENT BETWEEN THE FINANCIALLY RESPONSIBLE PARTY AND THE THIRD PARTY.

I affirm that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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

□ Mark if no orthodontic insurance

IF THERE IS ORTHODONTIC INSURANCE AND YOU WISH TO HAVE OUR OFFICE SUBMIT YOUR INSURANCE, PLEASE COMPLETELY FILL OUT THE FOLLOWING INSURANCE SECTION AND SIGN BELOW:

PRIMARY ORTHODONTIC INSURANCE Company Name_____

Insurance Co. Address_____

Insurance Co.Phone #_____Group #_____Member ID or Soc Sec#_____

Insured's Name_____ Relation_____

Insured's employer_____Insured's birthdate_____

SECONDARY ORTHODONTIC INSURANCE Company Name_____

Insurance Co. Address_____

Insurance Co.Phone #_____Group #_____Member ID or Soc Sec #_____

Insured's Name_____ Relation_____

Insured's employer_____Insured's birthdate_____

I authorize the release of information relating to orthodontic claims. I understand that I am responsible for all costs of treatment.

X

_____ _____

Signed (Parent or Guardian) Date

I authorize payment directly to Mountain View Orthodontics of the insurance benefits otherwise payable to me.

X

_____ _____

Signed (insured person) Date