MOUNTAIN VIEW ORTHODONTICS
F. RICHARD BECKWITH DDS, MS, PC
Specialist in Orthodontics

Under 18 Update

Child's Name_____ Prefers to be called _____ Today's Date: ____/____/____

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

E-mail (to confirm appts) _____ School_____ Grade_____

Favorite School Subjects_____ Hobbies/Sports/Musical Instruments_____

Who is accompanying your child today?_____ Relation_____

Person responsible for making appts:_____Child's Gen. Dentist _____Last dental exam_____/_____

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

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
Does your child have any dental problems at this time (pain, cavities, jaw joint (TMJ) pain, etc.)?	Y	N

Does your child have 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_____

Please list any health concerns or allergies that have developed since you last completed our health history form on the date listed at the top left of this sheet:_____

_____

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?**____/____

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Child lives with: Both parents____ Mother____ Father____ Other_____

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

Mother's address, phone, employer and work phone:_____ None of these have changed / New Address: _____
_____Phone:_____Employer_____Work Phone_____

Father's address, phone, employer and work phone:_____None of these have changed / New Address: _____
_____Phone:_____Employer_____Work Phone_____

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

Please continue to the next page with insurance information

□ Please check here if no orthodontic insurance

□ Please check here if there have been no changes in your orthodontic insurance since the last update noted at the top left of page 1

PLEASE COMPLETELY FILL OUT THE INSURANCE SECTION(S) BELOW TO PROVIDE US WITH THE NECESSARY INFORMATION FOR ACCESS TO YOUR INSURANCE BENEFIT INFORMATION AND/OR CLAIM SUBMISSION.

IS THIS AN INSURANCE COMPANY CHANGE / or NEW INSURANCE COVERAGE? (CIRCLE ONE)

If this is an insurance company change, please provide the following:

Name of the **former** insurance company_____ Date of Coverage termination____/____/____

PRIMARY ORTHODONTIC INSURANCE:

Insurance Co. Name_____

Insurance Co. Address_____

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

Insured's Name_____ Relation_____

Insured's employer_____Insured's birthdate_____

Effective date of coverage____/____/____ **Is the coverage under the COBRA Act? Y or N**

If the coverage is COBRA, on what date did the coverage change from standard to COBRA?____/____/____

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

X_____

I hereby authorize payment directly to F. Richard Beckwith, DDS insurance benefits otherwise payable to me.

X_____

SECONDARY ORTHODONTIC INSURANCE:

IS THIS AN INSURANCE COMPANY CHANGE / NEW INSURANCE COVERAGE? (CIRCLE ONE)

If this is an insurance company change, please provide the following:

Name of the **former** insurance company_____ Date of Coverage termination____/____/____

Secondary Insurance Co. Name_____

Insurance Co. Address_____

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

Insured's Name_____ Relation_____

Insured's employer_____Insured's birthdate_____

Effective date of coverage____/____/____ **Is the coverage under the COBRA Act? Y or N**

If the coverage is COBRA, on what date did the coverage change from standard to COBRA?____/____/____

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

X_____

I hereby authorize payment directly to F. Richard Beckwith, DDS insurance benefits otherwise payable to me.

X_____