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_____

Child lives with: Both parents___ Mother___ Father___ Other_____ School_____ Grade____

E-mail (to confirm appts) _____

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 or had orthodontic treatment before? 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
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) or face?	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_____

Airway: Please circle if: adenoids / tonsils / or both / have been removed? When? _____/_____	Y	N
Do they snore when sleeping? If so, please circle one. Nightly / Frequently / Occasionally	Y	N

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

Breathe through mouth when awake	Y	N	Thumb/finger sucking	Y	N
Sleep with their lips apart	Y	N	Speech problems	Y	N
Clenching/grinding teeth - awake	Y	N	Tongue thrust	Y	N
Clenching/grinding teeth - sleeping	Y	N	Smoke or chew tobacco	Y	N

Please explain any 'Y' answers above_____

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

Did/does your child have:

Any health problems	Y	N	Substance abuse problem	Y	N
Ever have to be hospitalized	Y	N	Psychiatric counseling	Y	N
Abnormal delivery as infant	Y	N	Frequent or severe headaches	Y	N
Asthma/respiratory problems	Y	N	Epilepsy/seizures	Y	N
Heart Murmur, heart disease,	Y	N	Sensory or Anxiety issues	Y	N
Diabetes	Y	N	Lip or inside mouth lesions (sores)	Y	N
Cancer, radiation or chemotherapy	Y	N	**Allergies**: Penicillin allergy	Y	N
Prolonged bleeding or Anemia	Y	N	Latex, vinyl, or acrylic allergy	Y	N
Bone fractures, any major accidents	Y	N	Nickel or other metal allergy	Y	N
Thyroid or other hormone therapy	Y	N	Other allergies:_____		

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. The following information is requested to assist us in evaluating jaw/overall growth potential**:**

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

Child's height :_____ Biological father's height:_____ Biological mother's height:_____ **OVER>>>>**

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.

PRIMARY ORTHODONTIC INSURANCE: **IF YOU WISH TO HAVE OUR OFFICE SUBMIT YOUR INSURANCE, PLEASE COMPLETELY FILL OUT THE INSURANCE SECTION.**

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co.Phone #_____Group #_____Social Security #_____

Insured's Name_____ Relation_____

Insured's employer_____Insured's birthdate_____

SECONDARY ORTHODONTIC INSURANCE:

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co.Phone #_____Group #_____Social Security #_____

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 (Patient, or parent if minor) Date

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

X

_____ _____

Signed (insured person) Date

I understand 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