

Today's Date \_\_\_/\_\_\_/\_\_\_

Health & Information--child **UNDER 18 Update**

Name \_\_\_\_\_ Prefers to be called \_\_\_\_\_ Birth date \_\_\_/\_\_\_/\_\_\_ Birth Sex \_\_\_

Child's Hm. Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Child's Hm. phone \_\_\_\_\_

E-mail (to confirm appts) \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Favorite School Subjects \_\_\_\_\_ Hobbies/Sports/Music 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

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

**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 any of the following tendencies or habits?**

Lips apart/mouth breathe - Awake Y N Wake up often in the night Y N

Lips apart/mouth breathe - Asleep Y N Thumb/finger suck or tongue thrust Y N

Clenching/grinding teeth - Awake Y N Speech concerns or therapy Y N

Clenching/grinding teeth - Asleep Y N Substance abuse problems Y N

Move around/restless during sleep Y N Smoke, Vape 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: \_\_\_\_\_

Any significant events in the past year or anything else we should know before treating your child? Y N \_\_\_\_\_

**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: \_\_\_\_\_ Relation \_\_\_\_\_

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

**Parent 1** address, phone, employer and work phone: \_\_\_\_\_ None of these have changed / New Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**Parent 2** 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.

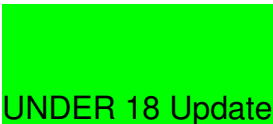
I affirm that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature

Date

**Please continue to the next page with insurance information**

**OVER>>>>**



Today's Date \_\_\_/\_\_\_/\_\_\_

Health & Information--child **UNDER 18 Update**

Child's name \_\_\_\_\_

(page 2 of 2)

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.

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

X \_\_\_\_\_

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.

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

X \_\_\_\_\_

X \_\_\_\_\_