Welcome

MERRILL & WEEK ORTHODONTICS

Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

801 Eastmont Avenue, Suite B, East Wenatchee, WA 98802 www.WenatcheeOrtho.com **509-886-4746**

About Your Child

Today's Date: _____

Legal Name: _____ (First / Last / MI)

Preferred Name: _____

Birthdate: _____ **Age:** _____ **Birth Sex:** _____

Home Address: _____

_____ (City / State / Zip Code)

School: _____ **Grade:** _____

Sports / Hobbies: _____

_____

List siblings with age: _____

_____

Parent / Legal Guardian Information

Name: _____ (First / Last) **Birthdate:** _____

Mother: ___ **Father:** ___ **Step-Mother:** ___ **Step-Father:** ___ **Other:** _____

Billing Address: _____

_____ (City / State / Zip Code)

E-Mail Address: _____

Cell #: _____ **Work #:** _____

Employer: _____

Job Title: _____ **How long there?** _____

Marital Status:
Single: ___ ***Married:*** ___ ***Partnered:*** ___ ***Divorced:*** ___ ***Widowed:*** ___ ***Separated:*** ___

Spouse or Secondary Guardian Information

Name: _____ (First / Last) **Birthdate:** _____

Mother: ___ **Father:** ___ **Step-Mother:** ___ **Step-Father:** ___ **Other:** _____

Billing Address: _____

_____ (City / State / Zip Code)

E-Mail Address: _____

Cell #: _____ **Work #:** _____

Employer: _____

Job Title: _____ **How long there?** _____

Additional Information

Who is accompanying the child today?

Name: _____ **Relation:** _____

Who is responsible for scheduling appointments?

Name: _____ **Phone #:** _____

Whom may we thank for referring you?

Name: _____

Emergency Contact

Name: _____

Relation: _____

Phone #: _____

Address: _____

_____ (City / State / Zip Code)

Primary Orthodontic Insurance

Orthodontic Coverage? **YES / NO**

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

ID# / Social Security #: _____
(Required for orthodontic insurance verification only)

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Policy Owner's Employer: _____

* ***Merrill & Week Orthodontics is only contracted with state insured patients for craniofacial anomalies.***

Secondary Orthodontic Insurance

Orthodontic Coverage? **YES / NO**

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

ID# / Social Security #: _____
(Required for orthodontic insurance verification only)

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Policy Owner's Employer: _____

Medical History

Please describe your child's current physical health:
GOOD FAIR POOR

Please list all medications that your child is currently taking:

_____

_____

Is your child allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics
Y	N	Penicillin	Y	N	Any Metals / Plastics
Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex
Y	N	OTHER			

Please list additional allergies: _____

_____

Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Heart Murmur
Y	N	Anemia	Y	N	Hemophilia
Y	N	Artificial Bones/Joints/Valves	Y	N	Hepatitis
Y	N	Asthma	Y	N	High / Low Blood Pressure
Y	N	Arthritis	Y	N	HIV+ / AIDS
Y	N	Blood Transfusions	Y	N	Lupus
Y	N	Cancer / Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Mental Illness
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug / Alcohol Abuse	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Severe / Frequent Headache
Y	N	Epilepsy / Seizures	Y	N	Sinus Problems
Y	N	Fainting	Y	N	Sexually Transmitted Disease
Y	N	Fever Blisters / Herpes	Y	N	Tuberculosis (TB)
Y	N	Handicaps / Disabilities	Y	N	Ulcers / Colitis
Y	N	Hearing Impairment			

Please list any other serious medical condition(s) that your child has had:

_____

_____

_____

Physician Name: _____

Phone #: _____ **Date of last visit:** _____

Has puberty begun? YES / NO

Has menstruation begun? (Girls) YES / NO

Dental History

General Dentist: _____

Last Visit Date: _____

What are the main concerns that you would like orthodontics to accomplish for your child? _____

_____

Has your child ever had or been evaluated for orthodontics treatment before? YES / NO

Has your child ever had a serious/difficult problem associated with any previous dental work? YES / NO

Have there been any injuries to their: FACE MOUTH TEETH CHIN

List any musical instruments played: _____

Have adenoids or tonsils been removed? YES / NO

Does your child have any missing or extra teeth? YES / NO

Does your child currently or have a history of pain / discomfort in their jaw joint (TMJ/TMD)? YES / NO

Your child's current dental health is: GOOD FAIR POOR

Does your child like their smile? YES / NO

Does your child brush their teeth daily? YES / NO

Floss their teeth daily? YES / NO

Do their gums ever bleed? YES / NO

Does your child have any speech problems? _____

Do they generally breathe through their mouth? YES / NO
If yes, please circle: While Awake? While Asleep?

Has your child ever experienced any of the following?

Y	N	Clenching/Grinding Teeth	Y	N	Speech Problems
Y	N	Snoring	Y	N	Nail Biting
Y	N	Thumb/Finger Sucking	Y	N	Tongue Thrust
Y	N	Lip Sucking / Biting	Y	N	Mouth Breather

- I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.
- Our Privacy Policy is on our website: www.WenatcheeOrtho.com. If you would like a paper copy, please request one.
- The parent or guardian who accompanies the child is responsible for payment.

_____ _____
Signature of Parent or Guardian **Date**

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: _____

_____

Initials: _____ **Date:** _____