WELCOME

MERRILL 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.

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____
LAST FIRST MI

E-mail Address: _____

Birthdate: ___/___/___ Age: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies/Sports: _____

Child's Home #: (____) _____

Child's Home Address: _____
APT/CONDO#

_____
CITY STATE ZIP

2 Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

How did you hear about us? _____

List brothers / sisters with age: _____

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Partnered ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

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☐ **Mother's Information** ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ___/___/___

Wk#: (___) _____ Ext: ____ Hm#: (___) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____

☐ **Father's Information**: ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ___/___/___

Wk#: (___) _____ Ext: ____ Hm#: (___) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS#: _____

4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

City State Zip

Previous Address: _____

City State Zip

Hm# (___) _____

Employer: _____

Wk# (___) _____ Ext: _____ SS#: _____

Who is responsible for making appointments?

Name: _____

Wk# (___) _____ Ext: _____ HM#: _____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐Yes ☐No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID#: _____

Policy Owner's Employer: _____

Employer's Address: _____

_____
City State Zip

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

_____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played:_____

Have adenoids or tonsils been removed?: ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician:_____

Phone #: (____) _____ Date of Last Visit:_____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all medications that your child is currently taking:

_____

Please list all medications / things that your child is allergic to:

_____

Y N Latex Y N Metals/Nickel Y N Plastics

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

Y	N	Abnormal Bleeding	Y	N	Convulsions/Epilepsy
Y	N	ADD / ADHD	Y	N	Diabetes
Y	N	Allergies to any Drugs	Y	N	Handicaps/Disabilities
Y	N	Allergic to Latex/Metals	Y	N	Hearing Impairment
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones / Joints / Valves	Y	N	HIV+ / AIDS
			Y	N	Kidney/Liver Problems
Y	N	Asthma	Y	N	Lupus
Y	N	Cancer	Y	N	Rheumatic/Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

_____

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Has your child ever experienced any of the following?

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

Neighbor or Relative not living with you.

Name_____ Phone (_____) _____

Address _____

_____

CITY STATE ZIP

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- 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 child's medical status.
- Our Privacy Policy is on our website: www.merrillorthodontics.com. If you would like a paper copy, please request one.
- The Parent or Guardian who accompanies the child is responsible for payment. **I hereby authorize OrthoBanc, LLC, on behalf of Merrill Orthodontics to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.**
  NOTE: *Obtaining an OrthoBanc credit recommendation does not alter the responsible party's credit score in any way*

_____

Signature of parent or guardian Date

Our office is HIPAA 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:_____

_____

_____