WELCOME

TO THE ORTHODONTIST

Dr. Joseph Arvay Dr. Michael Goldkind

Tell us about your child

Today's Date: _____

Child's Name: _____

Birthdate: _____/_____/_____ Child's Age: _____

Preferred Name: _____ ☐ Male ☐ Female

Child's Home #: _____

Child's Home Address:

_____

_____

Who is accompanying the child today?

Name: _____ Relation: _____

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

Whom may we thank for referring you? _____

_____

List brothers / sisters with age:_____

_____

General Dentist: _____

Last Visit Date: _____

Parental Information

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: _____

Address(if different)_____

Birthdate: ____/____/____ Home # _____

Work # _____ Cell # _____

Occupation:_____

E-Mail:_____

☐ **Father** ☐ Step Father ☐ Guardian

Name: _____

Address(if different) _____

Birthdate: ____/____/____ Home # _____

Work # _____ Cell # _____

Occupation:_____

E-Mail:_____

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

Primary Ortho Insurance

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

Insurance Co. Name: _____

Insurance Policy ID #:_____

Policy Owner's Employer: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Insurance Co. Group #: _____

Secondary Ortho Insurance

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

Insurance Co. Name: _____

Insurance Policy ID #:_____

Policy Owner's Employer: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Insurance Co. Group #: _____

I certify that my child is covered by the above Insurance Co. and I assign directly to Joseph M. Arvay DMD all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature of parent or guardian Date

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

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? **Y** **N**

Have there been any injuries to the face, mouth, teeth or chin? **Y** **N**

List any musical instruments played:_____

Have adenoids or tonsils been removed? **Y** **N**

Has your child been informed of any missing or extra permanent teeth? **Y** **N**

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? **Y** **N**

Does the child brush his / her teeth daily? **Y** **N**

Floss his / her teeth daily? **Y** **N**

Child's Physician: _____

Phone # _____ Date of last visit: _____

Is your child currently under the care of a physician? **Y** **N**

Has puberty begun? **Y** **N**

Has menstruation begun? (girls) **Y** **N**

Please describe the child's current physical health:

Good Fair Poor

Please list all medications the child is currently taking:

_____

Aside from items listed below, list all medications/things the child is allergic to:

_____

Latex **Y** **N** Metals/ Nickel **Y** **N** Plastic **Y** **N**

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

Y	**N**	Abnormal Bleeding	**Y**	**N**	Handicaps/Disabilities
Y	**N**	ADD / ADHD	**Y**	**N**	Hearing/Vision Loss
Y	**N**	Anemia	**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**	Hives
Y	**N**	Asthma	**Y**	**N**	HIV+ / AIDS
Y	**N**	Autism/Asperger's/PDD	**Y**	**N**	Kidney/ Liver Problems
Y	**N**	Cancer	**Y**	**N**	Measles
Y	**N**	Chicken Pox	**Y**	**N**	Mononucleosis
Y	**N**	Congenital Heart Defect	**Y**	**N**	Rheumatic/ Scarlet Fever
Y	**N**	Convulsions	**Y**	**N**	Sensory Issues
Y	**N**	Diabetes	**Y**	**N**	Sickle Cell Disease/Traits
Y	**N**	Epilepsy	**Y**	**N**	Skin Rash
Y	**N**	Exposed to HIV, but Neg.	**Y**	**N**	Tuberculosis (TB)

Are the child's immunizations current? **Y** **N**

Anything you would like to discuss with the Doctor in private? **Y** **N**

Please discuss any serious medical problem that the child has had: _____

_____

_____

Does / did the child have any of the following habits?

Y	**N**	Lip Sucking / Biting	**Y**	**N**	Nursing Bottle Habits
Y	**N**	Nail Biting	**Y**	**N**	Thumb/Finger Sucking

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 confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of parent or guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

____ Individual refused to sign

_____

Signature of parent or guardian Date