RESET THIS FORM

RACHEL E REICHARD DDS MS
orthodontics

CHILD INFORMATION

Last Name: _____First: _____Middle: _____

Nickname:_____ Date of Birth: _____ _____ _____ Sex: ☐ Male ☐ Female

Home Address:_____

City: _____ State: _ Zip Code:_____

School: _____ Grade:_____

GENERAL INFORMATION

Whom may we thank for referring you? _____

General Dentist: _____Date of last visit: _____

PARENT INFORMATION

Father's Information ☐ Father ☐ Stepfather ☐ Guardian	**Mother's Information** ☐ Mother ☐ Stepmother ☐ Guardian
Name: _____ Title Address: _____ City: _____State: Home Phone: _____ Cell Phone: _____ Employer: _____ Work Phone: _____ Preferred E-mail: _____	Name: _____ Title Address: _____ City: _____State Home Phone: _____ Cell Phone: _____ Employer: _____ Work Phone: _____ Preferred E-mail: _____
If you have Orthodontic Insurance Coverage, please fill out below:	
Insurance Co Name:_____ Insurance Co Address:_____ Insurance Co Phone: _____ Group Number: _____ Insured's Name:_____ Relationship to patient: _____ Insured's Date of Birth:_____ Insured's SSN/Insurance ID#: _____	Insurance Co Name:_____ Insurance Co Address:_____ Insurance Co Phone:_____ Group Number: _____ Insured's Name: _____ Relationship to patient: _____ Insured's Date of Birth:_____ Insured's SSN/Insurance ID#: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of person responsible for making appointments: _____

Name of person responsible for account: _____

Billing Address: _____City:_____State: _

Home Phone: _____Work Phone: _____Cell Phone:_____

Employer: _____

DENTAL HISTORY

What are the main concerns that you would like to address with orthodontic treatment?

_____

Has your child been evaluated for orthodontic treatment before? □ Yes □ No

Has your child ever had an injury to his/her mouth, teeth or chin? □ Yes □ No

Have adenoids or tonsils been removed? □ Yes □ No

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

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

Does your child have any of the following habits?

Thumb/Finger Sucking	□ Yes □ No	Mouth Breathing	□ Yes □ No	Clenching/grinding teeth	□ Yes □ No	Nail Biting	□ Yes □ No
Lip biting/sucking	□ Yes □ No	Speech Problems	□ Yes □ No	Nursing bottle habits	□ Yes □ No	Tongue Thrust	□ Yes □ No

MEDICAL HISTORY

Describe your child's current physical health: □ Good □ Fair □ Poor

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

Physician Name: _____Phone: _____

Address: _____

Please list all medications that your child is currently taking: _____

Please list all drugs that your child is allergic to: _____

Has your child reached puberty (menstruation, voice change)? □ Yes □ No How long ago? _____

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

Arthritis	□ Yes □ No	Allergy to Latex/Metals	□ Yes □ No	Heart Murmur	□ Yes □ No	Congenital Heart Defect	□ Yes □ No
Asthma	□ Yes □ No	Epilepsy/Convulsions	□ Yes □ No	Diabetes	□ Yes □ No	Abnormal Bleeding	□ Yes □ No
Rheumatic Fever	□ Yes □ No	Hearing Impairments	□ Yes □ No	HIV+/AIDS	□ Yes □ No	Any Operations	□ Yes □ No
Hemophilia	□ Yes □ No	Hospital Stays	□ Yes □ No	Cancer	□ Yes □ No	Kidney/Liver Problems	□ Yes □ No
Hepatitis	□ Yes □ No	Handicaps/Limitations	□ Yes □ No	Tuberculosis	□ Yes □ No	Frequent Headaches	□ Yes □ No

If yes, please describe: _____

_____

I acknowledge that I have received this office's Privacy Practice Notice

Signature: _____Date: _____

I understand that this information 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.

Signature: _____Date: _____