Child Form
Under 18

W E L C O M E

TO THE SMILE DR.

"We Make Our Patients' Smile"

Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____
Last First MI

Child's Birthday: __/__/__ Age: _____ ☐ Male ☐ Female

School: _____

Hobbies/Sports: _____ Grade: _____

Child's Home #: ( ) _____ SS#: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

General Information

Whom may we thank for referring you? _____

Other Siblings: _____

General Dentist: _____

Dentist's Phone #: ( ) _____ Last Visit Date: _____

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

_____

_____

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

☐ Yes ☐ No Was it in our office? (Please specify) _____

Have any of your siblings been treated for orthodontics in our office?

(Please specify) _____

Email: _____ This Email belongs to: _____

For online access to appointments, financials, treatment photos & x-rays, and much more!

Parent's Information

Name of person responsible for account: _____ Do you have legal custody of this child? ☐ Yes ☐ No

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

☐ Father ☐ Step Father ☐ Guardian

Name: _____ Birth date: __/__/__

Address: (If different than child's)

_____

_____

SS #: _____ DL #: _____

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

Cell/Other #: ( ) _____ Best way to reach you: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

If you carry Orthodontic Insurance Coverage for the child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone: ( ) _____

Group # / ID #: _____

☐ Mother ☐ Step Mother ☐ Guardian

Name: _____ Birth date: __/__/__

Address: (If different than child's)

_____

_____

SS #: _____ DL #: _____

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

Cell/Other #: ( ) _____ Best way to reach you: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

If you carry Orthodontic Insurance Coverage for the child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone: ( ) _____

Group # / ID #: _____

Continued on Back

Dental & Medical History

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No
Does the child require antibiotics before dental treatment? ☐ Yes ☐ No
Have adenoids or tonsils been removed? ☐ Yes ☐ No
Does your child have any missing or extra permanent teeth? ☐ Yes ☐ No
Has the child ever had any pain/ tenderness in his/her jaw joint? ☐ Yes ☐ No
Does the child brush his/ her teeth daily? ☐ Yes ☐ No
Floss his/ her teeth daily? ☐ Yes ☐ No
Child's Physician: _____
Phone #: _____ Date of last visit: _____
Is the child current under the care of a physician? ☐ Yes ☐ No
Has puberty begun? ☐ Yes ☐ No
Has menstruation begun? ☐ Yes ☐ No
Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Are the child's immunizations current? ☐ Yes ☐ No

Please list all drugs that the child is currently taking:

_____
_____
_____

Aside from items below, list all drugs/things child is allergic to:

_____
_____

☐Y ☐N Latex ☐Y ☐N Nickel/ Metals ☐Y ☐N Plastic

Please discuss any serious medical problems the child has had:

_____
_____

Has the child experienced the following medical problems?

☐Y ☐N Abnormal Bleeding	☐Y ☐N Hearing Impairment
☐Y ☐N ADD/ADHD	☐Y ☐N Heart Murmur
☐Y ☐N AIDS/HIV+	☐Y ☐N Hemophilia
☐Y ☐N Any hospital stays/ Operations	☐Y ☐N Hepatitis
☐Y ☐N Artificial bones/ Joints/ Valves	☐Y ☐N Kidney Problems
☐Y ☐N Asthma	☐Y ☐N Liver Problems
☐Y ☐N Cancer	☐Y ☐N Mitral Valve Prolapsed
☐Y ☐N Congenital Heart Defect	☐Y ☐N Prosthetics
☐Y ☐N Convulsions	☐Y ☐N Rheumatic Fever
☐Y ☐N Diabetes	☐Y ☐N Scarlet Fever
☐Y ☐N Epilepsy	☐Y ☐N Sickle Cell Disease/ Traits
☐Y ☐N Handicaps/ Disabilities	

Has the child ever been diagnosed with tuberculosis? ☐ Yes ☐ No
Has the child ever had a persistent cough greater than three weeks? ☐ Yes ☐ No
Has the child ever had a cough that produces blood? ☐ Yes ☐ No
Has the child ever taken any diet pills such as Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) If so, when? _____
Anything you would like to discuss with Dr. Kosiorek in private? ☐ Yes ☐ No

Does/ did the child experience any of the following?

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

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.
I understand that the information I have given is correct to the best of my knowledge, that is will be held at the strictest confidence and that 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/ orthodontic services my child may need.

_____
Signature of Parent or Guardian Date

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

I have verbally reviewed the medical/ dental information above with the parent/ guardian & patient named herein. _____
Signature of Dentist Date

Dentist's Comments: _____
_____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Yes ☐ No

Dentist Signature: _____ Date: _____ Parent/ Guardian Signature: _____ Date: _____