# BRIAN W PAYNE DDS

**orthodontic specialist for adults & children**

WE WOULD LIKE TO WECOME 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: _____

CHILD'S NAME: _____
LAST FIRST MI

NICKNAME: _____ ☐ MALE ☐ FEMALE

CHILD'S BIRTHDATE _____ CHILD'S AGE _____

SCHOOL: _____ GRADE: _____

GENERAL/PEDIATRIC DENTIST: _____
(PLEASE CIRCLE)
DATE OF LAST VISIT: _____

WHO MAY WE THANK FOR REFERRING YOUR CHILD? _____

## 2. WHO IS ACCOMPANYING THE CHILD TODAY

NAME: _____ RELATION: _____

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? ☐ YES ☐ NO

OTHER FAMILY MEMBERS SEEN BY US: _____

PARENT'S MARITAL STATUS: ☐ SINGLE ☐ WIDOWED ☐ SEPARATED ☐ MARRIED ☐ DIVORCED

## 3. PARENTAL INFORMATION

MOTHER: { ☐ STEP MOTHER ☐ GUARDIAN }

NAME: _____

ADDRESS: _____

HOME #: _____ WORK #: _____ EXT: _____

EMPLOYER: _____ SS#: _____

FATHER: { ☐ STEP FATHER ☐ GUARDIAN }

NAME: _____

ADDRESS: _____

HOME #: _____ WORK #: _____ EXT: _____

EMPLOYER: _____ SS#: _____

## 4. PERSON RESPONSIBLE FOR ACCOUNT

NAME: _____ RELATION: _____

BILLING ADDRESS: _____
STREET APT/CONDO #

_____
CITY STATE ZIP

HOME #: _____ WORK #: _____ EXT: _____

EMPLOYER: _____ SS#: _____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

NAME: _____

HOME #: _____ WORK #: _____ EXT: _____

## 5. PRIMARY DENTAL INSURANCE

DO YOU HAVE ORTHODONTIC COVERAGE? ☐ YES ☐ NO

INSURANCE CO. NAME: _____

INSURANCE CO. PHONE #: _____

GROUP # (PLAN OR POLICY #): _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S BIRTHDAY: ____/____/____ SS#: _____

INSURED'S EMPLOYER: _____

## 6. SECONDARY DENTAL INSURANCE

DO YOU HAVE ORTHODONTIC COVERAGE? ☐ YES ☐ NO

INSURANCE CO. NAME: _____

INSURANCE CO. PHONE #: _____

GROUP # (PLAN OR POLICY #): _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S BIRTHDAY: ____/____/____ SS#: _____

INSURED'S EMPLOYER: _____

## 7. 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

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 drugs your child is currently taking:_____

_____

Please list all drugs your child is allergic to:_____

_____

**SUBMIT**

## 8. Has your child ever been diagnosed or treated for any of the following?

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Cancer/Chemotherapy | ☐ | ☐ | Any Operations |
| ☐ | ☐ | Heart Murmur/Rheumatic Fever | ☐ | ☐ | HIV+/AIDS |
| ☐ | ☐ | Allergic to Latex / Metals | ☐ | ☐ | Hepatitis |
| ☐ | ☐ | Congenital Heart Defect | ☐ | ☐ | Handicaps / Disabilities |
| ☐ | ☐ | Allergic to Plastic | ☐ | ☐ | Fever Blisters |
| ☐ | ☐ | Severe Headaches | ☐ | ☐ | Psychiatric problems |
| ☐ | ☐ | Epilepsy/Seizures/Fainting | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Any Hospital Stays | ☐ | ☐ | Tuberculosis (TB) |
| ☐ | ☐ | Hemophilia/Abnormal Bleeding | ☐ | ☐ | Kidney Problems |
| ☐ | ☐ | Asthma | ☐ | ☐ | Arthritis |
| ☐ | ☐ | Tonsils Removed | ☐ | ☐ | Adenoids Removed |

Please discuss any medical problems that your child had:_____

_____

_____

## 9. Does your child have any of the following habits?

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Clenching / Grinding Teeth | ☐ | ☐ | Nursing Bottle Habits |
| ☐ | ☐ | Lip Sucking / Biting | ☐ | ☐ | Speech Problems |
| ☐ | ☐ | Mouth Breathing | ☐ | ☐ | Thumb / Finger Sucking |
| ☐ | ☐ | Nail Biting | ☐ | ☐ | Tongue Thrust |

*I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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.*

_____
Signature Date

**! Thank you for filling out this form completely. It will enable us to help treat your child more effectively. If you have any questions at any time, please ask us. We are happy to help.**

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, CDC AND THE ADA.

*A CREDIT REPORT MAY BE USED IN ORDER TO OFFER FLEXIBLE PAYMENT SCHEDULES.*

**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:** **Initial:**_____ **Date:**_____

_____

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