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 Lufkin, Texas 75904
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Nacogdoches
 808 N. University Dr.
 Nacogdoches, Texas 75961
 936.564.1218
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Crockett
 1050 E. Loop 304, Ste. 120
 Crockett, Texas 75835
 936.544.2855

Center
 514 Tenaha
 Center, Texas 75935
 936.564.1218

Please complete this form in its entirety. The better we communicate, the better we can care for your child.

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____
Last First MI

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

Whom may we Thank for referring you? _____

List brothers / sisters with age: _____

General Dentist: _____

Family Members treated here: _____

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

3 Parent's Information:

Mother Step Mother Guardian

Name: _____ Birthdate: ___/___/___

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

Cell #: (____) _____

Employer: _____

Job Title: _____

SS #: _____

E-mail Address: _____

Father Step Father Guardian

Name: _____ Birthdate: ___/___/___

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

Cell #: (____) _____

Employer: _____

Job Title: _____

SS #: _____

4 Person Responsible For Account

Name: _____ Relation: _____

Billing 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: ___/___/___ SS #: _____

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: ___/___/___ SS #: _____

Policy Owner's Employer: _____

Employer's Address: _____

CONTINUED ON BACK

6 DENTAL / MEDICAL HISTORY

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

Severe / Frequent Headaches? 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 that your child is currently taking: _____

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

7 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 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:

8 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

9 THANK YOU FOR COMPLETING THIS FORM IN ITS ENTIRETY!

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. 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.

Signature of Parent or Guardian _____ Date _____

If this office accepts insurance, 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. 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.

Signature of Parent or Guardian _____ Date _____

I authorize the dental staff to perform the necessary dental services that my child may need.

Signature of Parent or Guardian _____

Date _____

**The Parent or Guardian who accompanies the child is responsible for payment.
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

I verbally reviewed the medical / dental information above with the parent/guardian and patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____