David L. Way, D.D.S., M.S. ***Specialist in Orthodontics***

1.
CHILD'S INFORMATION

Today's date: _____ M_____F_____
Child's Name: _____
last first m
Nickname: _____SS# _____
Birth Date: _____Age: _____
School: _____Grade: _____
Home Phone #: (____) _____
Home Address: _____
_____
city state zip
List brothers/sisters with age: _____
_____
General Dentist: _____
Last visit date: _____

Parent's marital status: Single Married
Separated Widowed Divorced

2.
FATHER'S INFORMATION

Name: _____
Birth Date: _____
Hm # (____) _____Wk #: (____) _____
Email: _____
Employer: _____
SS #: _____

3.
MOTHER'S INFORMATION

Name: _____
Birth Date: _____
Hm #: (____) _____Wk #: (____) _____
Email: _____
Employer: _____
SS #: _____

4.
RESPONSIBLE PARTY

Name: _____
Relation: _____
Billing Address: _____
_____
city state zip
Previous Address: _____
_____
city state zip
Hm #: (____) _____Wk #: (____) _____
Employer: _____
SS #: _____

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: _____
Policy Owner's Birth Date: _____
SS #: _____
Policy Owner's Employer: _____

6.
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: _____
Policy Owner's Birth Date: _____
SS #: _____
Policy Owner's Employer: _____

7.
MEDICAL HISTORY

Y	N	Abnormal bleeding
Y	N	Allergies to any Drugs
Y	N	Allergic to Latex or Metals
Y	N	Allergic to Plastics
Y	N	Any Hospital Stays
Y	N	Any Operations
Y	N	Asthma
Y	N	Cancer
Y	N	Congenital Heart Defects
Y	N	Convulsions / Epilepsy
Y	N	Diabetes
Y	N	Handicaps / Disabilities
Y	N	Hearing Impairment
Y	N	Heart Murmur
Y	N	Hemophilia
Y	N	Hepatitis
Y	N	HIV+ / AIDS
Y	N	Kidney / Liver Problems
Y	N	Rheumatic Fever / Scarlet Fever
Y	N	Seasonal Allergies
Y	N	Tuberculosis

Please discuss any medical problems your child has had:

8.

WHY DID PATIENT / PARENT SEEK THIS CONSULTATION? _____

_____

_____

ORTHODONTIC CONSULTATION PROMPTED BY?

_____

_____

Who referred you to our office?

_____

Has your child ever been evaluated or had orthodontics 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 permanent teeth? Y N

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

Does your 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

Please describe your child's current physical health:

Good_____ Fair_____ Poor_____

Please list all drugs your child is currently taking:

_____

_____

Please list all drugs that your child is allergic to:

_____

_____

Briefly explain any other physical or mental conditions we need to be aware of:

_____

_____

_____

_____

_____

9.

DOES / DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y	N	Clenching / Grinding Teeth
Y	N	Lip Sucking / Biting
Y	N	Mouth Breather
Y	N	Nail Biting
Y	N	Nursing Bottle Habits
Y	N	Snoring
Y	N	Speech Problems
Y	N	Thumb / Finger Sucking
Y	N	Tongue Thrust

10.

EMERGENCY INFORMATION

Name of nearest relative not living with you:

_____

_____

Complete address: _____

_____

_____

Phone number: _____

11.

I HEREBY CERTIFY THAT I HAVE REVIEWED THE ABOVE MEDICAL / DENTAL HISTORY AND THAT IT IS ACCURATE TO MY KNOWLEDGE AT THIS TIME. IF THERE ARE ANY FUTURE CHANGES IN THE INFORMATION I WILL INFORM DR. WAY IMMEDIATELY.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Signature of Witness: _____

Date_____