WELCOME

TO FARLEY ORTHODONTICS

TELL US ABOUT YOUR CHILD Today's Date_____

Child's Full Name_____ Nickname_____ Birthdate_____ Age_____

Circle: Male or Female School_____ Grade_____ Hobbies_____

Child's Home Address_____Apt#_____City_____ Zip_____

WHO IS ACCOMANYING YOUR CHILD TODAY?

Name_____ Relation_____ Do you have legal custody of this child? Y or N

Whom may we thank for referring you? _____ General Dentist_____ Last Visit_____

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

MOTHER'S INFORMATION ☐Mother ☐Step Mother ☐Guardian Financially Responsible? Y or N

Name_____ Birthdate_____ Email_____

Cell #_____ Wk/Home #_____ SS#_____ Employer_____

Home Address _____Apt#_____City_____ Zip_____

FATHER'S INFORMATION ☐Father ☐Step Father ☐Guardian Financially Responsible? Y or N

Name_____ Birthdate_____ Email_____

Cell #_____ Wk/Home #_____ SS#_____ Employer_____

Home Address _____Apt#_____City_____ Zip_____

PRIMARY ORTHO INSURANCE Ortho Coverage? Y or N (please alert staff if you have secondary ins.)

INS Co._____ INS Co. Address_____

INS phone#_____ Group/Plan#_____ Subscriber_____ Relation to patient_____

Subscriber's Birthdate_____ Subscriber's Employer_____ SS/ID#(required)_____

MEDICAL/DENTAL HISTORY OF THIS CHILD

Has your child ever taken phen-Fen?.....Y N
Been evaluated for Orthodontic treatment before?.....Y N
Injuries to face, mouth, or chin?.....Y N
Have adenoids or tonsils been removed?.....Y N
Missing or extra permanent teeth?.....Y N
Pain or tenderness in jaw joint (TMJ/TMD)?.....Y N
Brush teeth daily?.....Y N
Floss teeth daily?.....Y N
Clenching/Grinding?.....Y N
Lip Sucking/Biting?.....Y N
Mouth Breather?.....Y N
Nail biting?.....Y N
Thumb Sucking?.....Y N
Tongue Thrust?.....Y N
Speech Problems?.....Y N

Child's Physician_____ Last Visit_____

Your child's current physical health: GOOD FAIR POOR

Please list all drugs your child is currently taking:

_____

Please List all drugs/things your child is allergic to:

_____

Latex Y N Metals/Nickel Y N Plastics Y N

Abnormal Bleeding..... Y N
ADD/ADHD.....Y N
Hospitalized.....Y N
Operations.....Y N
Artificial Joints/Valves .....Y N
Asthma.....Y N
Cancer.....Y N
Cong. Heart Defect.....Y N
Convulsions/Epilepsy.....Y N
Rheumatic/Scarlet Fever ...Y N

Diabetes..... Y N
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
Lupus.....Y N
Tuberculosis.....Y N

Other Medical Issues_____

I authorize the dental staff to perform the necessary dental service my child may need.
Parent/Guardian Signature Date

I understand that I am responsible for payment of services rendered and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to the office. I authorized the use of this signature on all my insurance submissions, whether manual or electronic.
Parent/Guardian Signature Date

I verbally reviewed the medical /dental history above with parent/guardian and patient named.
Doctor Signature Date