Welcome to our office.

Erickson - Aamodt Orthodontics

Patient I.D. _____

So that we might become better acquainted, please complete both sides of this form.

Date: _____

CHILD PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____ Sex: _____

Home Address: _____ City: _____ Zip: _____

Patient resides with: ❑ Mother ❑ Father ❑ Both ❑ Other: _____

Home Phone: _____ Age: _____ Birth date: _____ School: _____

Please describe your child's orthodontic problem in your own words: _____

Dentist (full name and address): _____

Whom may we thank for referring you to our office? _____

Names and ages of brothers/sisters: _____

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Single

	Mother	Father
Name:		
Relationship if other than parent:		
Address (if different from above):		
Phone (if different from above):		
Birth Date:		
Employer's Name:		
Business Address:		
Business Phone:		
Occupation:		

Person Responsible for Account: _____

Name of Relative in Area: _____ Phone: _____

Primary Dental Information

Subscriber Name: _____ Relationship to Patient: _____

Insurance ID # _____ Birth Date _____ Group # _____

Subscriber Employed by _____ Insurance Phone # _____

Insurance Company _____
Name Address City State Zip

Is there Secondary Dental Insurance? _____ No _____ Yes (If yes please provide a copy)

Benefit Assignment and Release

I authorize and request my insurance company(s) to pay Erickson-Aamodt Orthodontics insurance benefits otherwise payable to me. I authorize the release of all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Patient or Guardian if a minor Date

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: _____ Address: _____ Phone: _____

Has your child experienced any health problems? ☐ No ☐ Yes Explain: _____
Any major change in your child's health recently? ☐ No ☐ Yes Explain: _____
Is your child currently under physician's care? ☐ No ☐ Yes Explain: _____
Is your child currently taking medications? ☐ No ☐ Yes List: _____
Is your child allergic to any medications? ☐ No ☐ Yes List: _____
Has your child received a blood transfusion? ☐ No ☐ Yes Reason: _____
Have your child's tonsils or adenoids been removed? ☐ No ☐ Yes When: _____
Has your child been in a risk group for AIDS? ☐ No ☐ Yes Explain: _____

Please check if your child has had any of the following conditions:

Heart Murmur	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes	Emotional Problems	☐ No ☐ Yes
Heart Surgery	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes	Frequent Headaches	☐ No ☐ Yes
Rheumatic Fever	☐ No ☐ Yes	Kidney Disease	☐ No ☐ Yes	Nervous/Anxious	☐ No ☐ Yes
Endocrine Disorders	☐ No ☐ Yes	Liver Disease	☐ No ☐ Yes	Cancer	☐ No ☐ Yes
Prolonged Bleeding	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes	Bone Disorders	☐ No ☐ Yes
Anemia	☐ No ☐ Yes	Bronchitis	☐ No ☐ Yes	Growth Disorders	☐ No ☐ Yes
Blood Disease	☐ No ☐ Yes	Asthma	☐ No ☐ Yes	Mouth Breather	☐ No ☐ Yes
Developmental Disorder	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	Herpes (Fever Blisters)	☐ No ☐ Yes
Hives/Rash	☐ No ☐ Yes	Fainting	☐ No ☐ Yes	Tonsillitis	☐ No ☐ Yes

Is there any other condition or problem that you think we should know about? _____

Comments: _____

DENTAL HISTORY

Dentist's Name: _____ Address: _____ Phone: _____

Frequency of dental checkups: ☐ Twice a year ☐ Once a year ☐ Only if a problem exists ☐ Never Date of last visit: _____
Is there any unfinished care to be completed with your child's dentist? ☐ No ☐ Yes Explain: _____
Is your child frightened about dental treatment? ☐ No ☐ Yes Explain: _____
Has your child had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain: _____
Has your child had any face or dental injuries? ☐ No ☐ Yes Explain: _____
Is there any history of thumb or finger sucking? ☐ No ☐ Yes Stopped? _____
Does your child play any musical instrument? ☐ No ☐ Yes What instrument? _____
Has your child consulted an orthodontist previously? ☐ No ☐ Yes With whom? _____
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes
Has your child had any previous orthodontic **treatment**? ☐ No ☐ Yes With whom? _____
Are you satisfied with prior treatment? ☐ No ☐ Yes Explain: _____

Please check if there is a history of:

☐ Clenching teeth ☐ Muscular soreness around head & neck ☐ Jaw joint soreness ☐ Jaw joint popping
☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in the ears
☐ Speech problems (if so, which sounds _____) ☐ Mouthbreathing while: ☐ Awake ☐ Asleep

Is there any other information that may be helpful? _____

_____ _____ Reviewed by: _____
Parent's Signature Date