Pappas & Tapley Orthodontics

Please complete this form and bring it to your new patient appointment.
WE CAN'T WAIT TO MEET YOU!

PATIENT INFORMATION

Name of Minor/Child:	**Preferred Name:**	Today's Date:
Sex: ☐ Male ☐ Female		Date of Birth:
School and Grade:		Age:
Home Address: City/State/Zip		Home Phone: Patient's Email:
Hobbies:		
Whom may we thank for referring you:		General Dentist:

FAMILY INFORMATION

Father's Name:		Mother's Name:	
DOB:	S.S.#	DOB:	S.S.#
Home Address: *(if different from patient)*		Home Address: *(if different from patient)*	
Home Phone:		Home Phone:	
Employer:		Employer:	
Work Phone:		Work Phone:	
Email Address:		**Email Address:**	
Please list other family members treated here:			

DENTAL/ALLERGY HISTORY

Date of patient's last dental visit:		Purpose of last visit:		
What are the main concerns that you would like orthodontics to accomplish?				
Has your child been evaluated for orthodontic treatment before?		☐ Yes ☐ No		
Has your child had any injuries to the face, mouth or chin?		☐ Yes ☐ No		
Has your child been informed of any missing or extra permanent teeth?		☐ Yes ☐ No		
Has your child had any pain/tenderness in his/her jaw joint (TMJ/TMD)?		☐ Yes ☐ No		
Does your child brush his/her teeth daily?		☐ Yes ☐ No		
Does your child floss his/her teeth daily?		☐ Yes ☐ No		
Does your child play any musical instruments that involve the mouth?		☐ Yes ☐ No		
Has your child had any of these dental related problems:	Clenching/Grinding Teeth	☐ Yes ☐ No	Mouth Breather	☐ Yes ☐ No
	Lip Sucking/Biting	☐ Yes ☐ No	Nail Biting	☐ Yes ☐ No
	Speech Problems	☐ Yes ☐ No	Tongue Thrust	☐ Yes ☐ No
	Thumb/Finger Sucking	☐ Yes ☐ No		
Allergies: Does your child have any of these allergies?	Aspirin	☐ Yes ☐ No	Latex	☐ Yes ☐ No
	Codeine	☐ Yes ☐ No	Metals	☐ Yes ☐ No
	Dental Anesthetics	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
	Erythromycin	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No
	Other Allergies:			
Handicaps/Disabilities:				

More IMPORTANT details need to be completed on the back of this form. Thank you!

For Office Use ONLY	**Patient I.D. #**

MEDICAL HISTORY

Child's Physician:	Phone Number:	Date of Last Visit:
Emergency Contact:	Phone Number:	Relationship:

Medical Conditions:

Does your child have or has he/she had any of these medical conditions?

Abnormal Bleeding	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
ADD/ADHD	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Anemia/Radiation Treatment	☐ Yes ☐ No	Heart Attack/Disease	☐ Yes ☐ No
Artificial Bone/Joints/Valves	☐ Yes ☐ No	Hepatitis (☐ A ☐ B ☐ C)	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	High/Low Blood Pressure	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Kidney/Liver Problems	☐ Yes ☐ No
Cancer/Leukemia	☐ Yes ☐ No	Measles/Mumps	☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Congenital Heart Defects	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Problems	☐ Yes ☐ No
Drug/Alcohol Abuse	☐ Yes ☐ No	Rheumatic/Scarlet Fever	☐ Yes ☐ No
Fever Blisters	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Hearing Impairment	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Heart Attack/Problems	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No

Please list any current medications being used by your child and the reason for each:

RESPONSIBLE PARTY INFORMATION

Person Financially Responsible:	Date of Birth:
Relationship to Patient:	Social Security Number:
Home Address: *(if different from patient)*	Home Phone: Work Phone:
Employer:	**Email Address:**

RESPONSIBLE PARTY'S INSURANCE INFORMATION

Do you have orthodontic coverage for this minor? ☐ Yes ☐ No	Employer:
Insurance Company:	Insured's Name:
Relationship to Patient:	Insured's Date of Birth:
Insurance Claims Address:	Social Security # (required): Ins. ID #
Insurance Co. Phone:	Ins. Group #

Financial Information/ Signature Requirement	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/or deductibles that my insurance does not cover. **Signature of Parent or Guardian** **Date**	This office reserves the right to verify credit of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. **Signature of Parent or Guardian** **Date**
Treatment Authorization Signature Requirement	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. I authorize the dental staff to perform the necessary dental services my child may need. **Signature of Parent or Guardian** **Date**	

For Office Use ONLY	I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.
	Doctor' Comments: **Doctor's Initials:** **Date:**