JAY HARRIS ORTHODONTICS

CHILD/TEEN INFORMATION

Today's Date _____

Patient Name _____ Nickname _____
First Middle Last

☐ Male ☐ Female Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____ Carrier _____

Would you like to receive text reminders or email reminders? ☐ Text ☐ Email

Email Address _____ School _____ Grade _____

Whom may we thank for referring you? _____

Have we treated a family member? ☐ Yes ☐ No If yes, Name(s) _____

Name of General Dentist _____ Date of Last Visit _____

What are your primary goals for orthodontic treatment? _____

PARENTS INFORMATION

Father ☐ **Step-Father** ☐ **Guardian** ☐

Father's Name _____ D.O.B. _____ SS# _____

Mailing Address _____ City _____ State _____ Zip _____

single ☐ married ☐ separated ☐ divorced ☐ widow(er) ☐ Email _____

Employed By/Occupation _____ Work Phone _____

Home Phone _____ Cell Phone _____ Carrier _____

IF FATHER HAS INSURANCE COVERAGE FOR THIS CHILD, PLEASE FILL OUT THE FOLLOWING INFORMATION

Insurance Co. _____ Group # _____ ID# _____

Insurance Company's Address _____

Insurance Company's Phone Number _____

Mother ☐ **Step-Mother** ☐ **Guardian** ☐

Mother's Name _____ D.O.B. _____ SS# _____

Mailing Address _____ City _____ State _____ Zip _____

single ☐ married ☐ separated ☐ divorced ☐ widow(er) ☐ Email _____

Employed By/Occupation _____ Work Phone _____

Home Phone _____ Cell Phone _____ Carrier _____

IF MOTHER HAS INSURANCE COVERAGE FOR THIS CHILD, PLEASE FILL OUT THE FOLLOWING INFORMATION

Insurance Co. _____ Group # _____ ID# _____

Insurance Company's Address _____

Insurance Company's Phone Number _____

JAY HARRIS ORTHODONTICS

DENTAL AND MEDICAL HISTORY

Today's Date _____

Child's Physician _____ Date of Last Physical _____

Is the child currently undergoing any medical treatment? ☐ Yes ☐ No

If yes, for what reason? _____

History of major illness? ☐ Yes ☐ No If yes, please describe: _____

History of trauma or injury to the face or teeth? ☐ Yes ☐ No If yes, please describe: _____

_____

Any sensitivites or allergies? ☐ Yes ☐ No If yes, please list: _____

Currently taking any medications? ☐ Yes ☐ No If yes, please list: _____

Has the child been treated for any of the following?

☐ Arthritis ☐ Blood Disorder ☐ Diabetes ☐ Heart Condition ☐ Tuberculosis

☐ Asthma ☐ Cancer ☐ Epilepsy ☐ Nervous Disorder ☐ ADD/ADHD

Does the child require antibiotics prior to dental treatment? ☐ Yes ☐ No

Have the adenoids or tonsils been removed? ☐ Yes ☐ No

Has the child ever had pain or tenderness in the jaw joint (TMJ)? ☐ Yes ☐ No

Does the child have any of the following habits?

☐ Teeth Grinding ☐ Finger/Thumb Sucking ☐ Prolonged Bottle/Pacifier

☐ Mouth Breathing ☐ Speech Problems ☐ Chewing/Eating Problems

I, the undersigned, understand that responsibility for payment of Orthodontic Services provided for myself or my dependent is mine, but you will assist me with financial arrangements and insurance claims when necessary. I agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of the account. IF CREDIT IS EXTENDED FOR ORTHODONTIC FEES, YOUR CREDIT STATUS MAY BE VERIFIED BY A CREDIT AGENT.

Signature _____ Date _____