IVERSON ORTHODONTICS

A PERFECT FIT FOR YOUR TEETH

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WELCOME!

We want to welcome you and your child to our orthodontic practice. We are looking forward to an enjoyable association which will result in healthier teeth and a sensational smile. Before we begin, we ask that you fill out this form in ink as completely as you can. Please print. Thank you.

Patient Information - Child

Patient's Full Name____ Prefers to be called____________________________

Address ____

Age_____ Date of Birth_________________ Gender M / F School__________________________________ Grade_______

Hobbies/Interests ____

Referred to our office by____

Parent / Responsible Party Information

Full Name____ Relationship to Patient_____________________

Marital Status (Please circle one) Single Married Separated Divorced Widowed

Address____ # Years at address _______

Home Phone___________________________ Work Phone__________________Cell Phone____________________________

Email_______________________________ Social Security #________________________ Birthdate____________________

Employer______________________________ Occupation__________________________ No. Years Employed____________

Other Parent/Guardian____ Relationship to Patient_________________

Employer______________________________ Occupation__________________________ No. Years Employed____________

Email_______________________________ Social Security #________________________ Birthdate____________________

Home Phone___________________________ Work Phone__________________Cell Phone____________________________

Insurance Information

Policy Holder's Name____ Employer____________________________________

Insurance Company______________________________________ Group No.____________ Union Local No._______

Insurance Co. Address____ Insurance Co. Phone________________

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name____ and Employer_______________________

Insurance Company______________________________________ Group No.____________ Union Local No._______

Insurance Co. Address____ Insurance Co. Phone________________

Emergency Contact Information

Name of nearest relative not living with you____

Complete Address____

Phone________________________________ Relationship:____

Patient Medical History

Physician's Name____ Office Phone________________________________

How would you describe patient's current health? ___Excellent ___Good ___Fair ___Poor

Is patient currently under a doctor's care? ___Yes ___No If yes, for what?________________________________

Is patient currently taking any medications? ___Yes ___No If yes, please list________________________________

Does patient have any allergies to medications or latex? ___Yes ___No If yes, please list________________________________

Has puberty begun? ___Yes ___No

Does patient have a history of any of the following? Please check all that apply.

☐ Allergies	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Nervous/Anxious
☐ Anemia	☐ Epilipsy	☐ HIV/AIDS	☐ Psychiatric Care
☐ Asthma	☐ Fainting	☐ Hemophilia	☐ Rheumatic Fever
☐ Chicken Pox	☐ Hearing Problems	☐ Kidney Disease	☐ Thyroid Disease
☐ Diabetes	☐ Heart Problems	☐ Liver Disease	☐ Tuberculosis

Please list any other medical conditions not addressed above. ____

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Patient Dental History

Dentist's Name____ Date of last visit________________________

Has patient ever had an unfavorable experience with previous dental care? ___Yes ___No

Has patient been evaluated for or had orthodontic treatment before? ___Yes ___No

If you answered yes to the above, please explain____

What are the primary concerns and final objectives expected from orthodontic treatment? ________________________________

____

Does patient have a history of any of the following? Please check all that apply and give details below.

☐ Injuries to face, mouth or teeth	☐ Tonsils removed	☐ Tongue Thrust
☐ Pain or tenderness in jaw	☐ Plays a musical instrument by mouth	☐ Mouth breathing
☐ Missing or extra permanent teeth	☐ Thumb/Finger sucking	☐ Nail/Lip Biting
☐ Speech problems		☐ Clenching/Grinding Teeth

Details: ____

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Authorization and Release

Please Initial And Sign

_____ In accordance with HIPAA regulations, I understand that this information will be held in strict confidence. I hereby give my permission for the office of Iverson Orthodontics to use patient records for diagnosis, treatment, promotion, and education.

_____I authorize Dr. Iverson to release any information necessary for insurance purposes and authorize direct payment of insurance benefits to Dr. Iverson for services rendered.

Signature of Parent/Guardian____ Date__________________