Date:_____

Child Welcome Information

Patient's Name_____Nickname _____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Date of Birth _____ SSN _____

School_____Grade_____Hobbies or special interests?_____

Are there siblings? (names/ages)_____Dentist_____

Whom may we thank for referring you to our office? (Check all that apply):

- ☐ Dentist_____
- ☐ Friend/Family/Neighbor_____
- ☐ Internet (Where specifically?)_____
- ☐ Other_____
- ☐ Mansfield Cares
- ☐ Miles for Meredith
- ☐ School Field Trip
- ☐ Mansfield ISD Education Foundation
- ☐ Feed the Kids
- ☐ Location

What are the main concerns that you would like orthodontics to accomplish?_____

Dental Status

When was the patient last seen by the dentist? _____

- ☐Yes ☐No Has the patient had previous orthodontic treatment or consultation? When? Why? _____
- ☐Yes ☐No Has any member of the family had orthodontic treatment?_____
- ☐Yes ☐No Has the patient had any trouble associated with dental treatment? _____
- ☐Yes ☐No Has the patient had any teeth extracted? Why? _____
- ☐Yes ☐No Has the patient ever injured or broken any teeth? When and what happened? _____
- ☐Yes ☐No Has the patient ever injured the head or face? When and what happened? _____
- ☐Yes ☐No Does the patient have any missing or extra teeth? _____
- ☐Yes ☐No Does the patient have any problem with eating, chewing, or swallowing? _____
- ☐Yes ☐No Does the patient suck thumb, fingers, tongue, blanket, or pacifier? (circle which) _____
- ☐Yes ☐No Does the patient have any dental or facial pain?_____
- ☐Yes ☐No Does the patient's jaw joint make noises or hurt when opening, closing, or chewing?_____
- ☐Yes ☐No Does the patient habitually grind or clench the teeth together? _____
- ☐Yes ☐No Does the patient normally breathe with the lips parted? _____
- ☐Yes ☐No Is the patient aware of any swellings or growths in the mouth or face? _____
- ☐Yes ☐No Does the patient have negative or resistant feelings about orthodontic treatment? _____
- ☐Yes ☐No Is the patient especially concerned about orthodontic treatment?_____
- ☐Yes ☐No Is the patient dissatisfied with the appearance of the teeth?_____
- ☐Yes ☐No Is the patient especially resistant to: ☐ Braces ☐ Headgear ☐ Retainers
- ☐Yes ☐No Is there any other information we should know?_____

Medical History

Please list any:
Serious illness or condition _____
Allergies or known drug sensitivity _____
Current medical care _____
Current medications _____

Tonsils and Adenoids: ☐ Present ☐ Removed at age _____

☐Yes ☐No Does the patient have frequent colds or ear infections?

Has the patient ever been diagnosed or treated for the following (Check all that apply.):

- ☐ Rheumatic Fever
- ☐Heart Murmur
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Endocrine Disorders
- ☐Bone Disorder
- ☐Emotional Problems
- ☐Multiple Sclerosis
- ☐Asthma
- ☐Epilepsy
- ☐Herpes
- ☐Hepatitis
- ☐Low Blood Pressure
- ☐Tuberculosis
- ☐Bleeding Disorder
- ☐Cerebral Palsy
- ☐Cancer
- ☐AIDS or HIV+
- ☐Arthritis
- ☐Diabetes

Responsible Party Information

Name _____ Relationship to Patient _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address_____ Rent or Own?_____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

SSN _____ Date of Birth _____ Marital Status _____

Home Phone_____ Work Phone_____ Cell Phone _____ E-mail _____

Employer _____ Occupation _____ No. Years Employed _____

Employer's Address _____
Street City State Zip

Spouse's Name_____ Relationship to Patient _____
Last First Middle

SSN _____ Date of Birth _____

Work Phone_____ Cell Phone _____ E-mail _____

Employer _____ Occupation _____ No. Years Employed _____

Employer's Address _____
Street City State Zip

A B C

Insurance Information

Insured's Name_____ Relationship to Patient _____
Last First Middle

Insured's Mailing Address _____
Street City State Zip

Insured's SSN _____ Insured's Date of Birth _____ Home Phone _____ Work Phone _____

Insurance Company _____Group No. _____ Local No. _____ Employer _____

Insurance Co. Address_____
Street City State Zip

Insurance Co. Phone_____

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

Insured's Name_____ Relationship to Patient _____
Last First Middle

Insured's Mailing Address _____
Street City State Zip

Insured's SSN _____ Insured's Date of Birth _____ Home Phone _____ Work Phone _____

Insurance Company _____Group No. _____ Local No. _____ Employer _____

Insurance Co. Address _____
Street City State Zip

Insurance Co. Phone_____

Signature of Responsible Party

To the best of my knowledge, the information given is correct. Furthermore, I understand that it is my responsibility to inform this office of any changes in this patient's medical status or insurance information. I authorize Dr. Herrmann to perform a complete orthodontic evaluation including digital photos and 3D digital x-rays. I also understand that diagnostic records and name may be used in educational and promotional purposes. I also understand that in order to receive complete information on financial options, credit bureau reports may be obtained.

Signature: _____ Relationship to Patient: _____ Date: _____
Type full name

PRINT