VARGHESE ORTHODONTICS

It's all about your smile

CHILD FORM

Date: _____

Child's Name _____ Birthdate _____ Male ☐ Female ☐

Home #: _____ School: _____ Grade: _____

Email: _____ Nickname/Preferred Name: _____

Home Address: _____

Whom may we thank for referring your child? _____

PARENT INFORMATION

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Mother's Name:_____

Home #: _____ Cell #: _____ Work #: _____

Home Address: _____

Email Address: _____

Father's Name:_____

Home #: _____ Cell #: _____ Work #: _____

Home Address: _____

Email Address: _____

INSURANCE INFORMATION

Primary Insurance: Dental Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name: _____Phone #: _____Insured's Birthdate: _____

Insured's Social Security #:_____ Insurance Co. Address: _____

Insured's Name:_____Relationship:_____ Group (Plan/Local/Policy)#: _____

Insured's Employer: _____ Employer's Address: _____

Secondary Insurance: Dental Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name: _____Phone #: _____Insured's Birthdate: _____

Insured's Social Security #:_____ Insurance Co. Address: _____

Insured's Name:_____Relationship:_____ Group (Plan/Local/Policy)#: _____

Insured's Employer: _____ Employer's Address: _____

DENTAL HISTORY

Primary reason for today's visit: _____

Does your child brush his/her teeth daily? _____Floss his/her teeth daily? _____

Present Dentist: _____ Date of last visit: _____

What did you like most about any dentist you have seen? _____Least? _____

Have there been any injuries to the face, mouth , or teeth? Yes____ No____ If yes, explain:_____

Does/did your child have any of the following habits?

☐Lip Sucking/Biting ☐Clenching/Grinding ☐Teeth Tongue/Cheek Biting ☐Mouth Breather
☐Nail Biting ☐Thumb/Finger Sucking ☐Used Pacifier ☐Speech Problems
☐Chewing on Objects ☐Nursing Bottle Habits ☐Tongue Thrust

MEDICAL HISTORY

Child's Physician: _____Phone #: _____Date of Last Visit: _____

Address: _____

Is your child currently under the care of a physician? ☐Yes ☐No Please Explain: _____

Describe your child's current physical health: Good Fair Poor Are immunizations current? ☐Yes ☐No

Please list all drugs that your child is currently taking: _____

Please list all drugs and/or things that cause your child allergic reactions: _____Allergy to latex?____

Anything you would like to discuss with the doctor in private? ☐Yes ☐No

Has your child had/experienced any of the following?

☐Abnormal Bleeding ☐Congenital Heart Defect ☐High/Low Blood Pressure ☐Rheumatic Fever
☐AIDS/HIV+ ☐Diabetes ☐Kidney Problems ☐Scarlet Fever
☐Allergies ☐Epilepsy/Convulsions ☐Liver Problems ☐Sickle Cell Anemia
☐Anemia ☐Handicaps/Disabilities ☐Lupus ☐Skin Rash
☐Asthma ☐Hearing Impairment ☐Measles ☐Tonsilitis
☐Blood Transfusion ☐Heart Murmur ☐Mitral Valve Prolapse ☐Tuberculosis (TB)
☐Cancer/Chemo ☐Hemophilia ☐Mononucleosis
☐Chicken Pox ☐Hepatitis ☐Operation

Please discuss any serious medical problems your child has experienced: _____

_____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that 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 services that my child may need. I also understand that my diagnostic records may be used for educational and promotional purposes. I assign Dr. Varghese all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible and co-payment that my insurance does not cover. I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____Date: _____