Ted Vossers, DDS, MS, PA

Child Orthodontic Patient Information

Date ___/___/___ -Please Print- Date of Birth____/____/____

Update___/___/___

Patient Name ______________________________________ Sex ________ SS# ___________________________

Home Address ____ Preferred Name______________________

____ Home Phone________________________

Family Email Address ______________________________________ Cell Phone___________________________

Occupation/School ____________________ Employer/Grade ___________________ Work Phone______________

Hobbies/ Interests____

Whom may we thank for recommending our office to you?____

Physician ______________________________ Family Dentist ________________ Last Dental Visit____________

Please list any family members treated here ____

Names & ages of brothers and sisters____

Person responsible for payment of the account _______________________ Relationship______________________

Orthodontic Insurance? ____________________________________ Company Name ________________________

Parents are (circle one): Single Married Separated Divorced Widowed Other_____________________

Father's Name __________________________ SS#___________________________ D.O.B.________________

Address if different____

Occupation __________________ Employer _____________________________ Business Phone ______________

Cell#_______________________ Home#___________________________ Best DaytimeContact_____________

Mother's Name _________________________ SS#____________________________ D.O.B.__________________

Address if different____

Occupation __________________ Employer ______________________________ Business Phone _____________

Cell#________________________ Home#_________________________ BestDaytimeContact_______________

Emergency Contact If parents can't be reached_____________________________ Phone______________________

MEDICAL HISTORY

Yes No Any major or unusual illnesses?
Explain____

Yes No Currently under physician's care?
Reason____

Yes No Have taken or are taking Bisphosphonates(ex: Fosomax)?
How long ago?____

Yes No Currently taking medication?
List____

Yes No Any drug allergies/sensitivities?
List____

Please turn over to back of page

MEDICAL HISTORY CONTINUED

Yes No PreMed for Dental Treatment
Yes No Joint Replacement

Yes No Heart Murmur	Yes No Hepatitis/Liver Disease	Yes No Speech/ Hearing Problems
Yes No Rheumatic Fever	Yes No Heart Trouble	Yes No Allergies
Yes No Epilepsy	Yes No High Blood Pressure	Yes No Diabetes
Yes No Fainting/Dizziness	Yes No Cold Sores/ Herpes	Yes No Frequent Colds/Flu
Yes No Asthma	Yes No AIDS Antibody Positive	Yes No Tonsilitis/ Adenitis
Yes No Glaucoma	Yes No Abnormal Bleeding	Yes No Tonsils/ Adenoids Removed
Yes No Contact Lenses	Yes No Frequent Headaches	Yes No Tuberculosis

GROWTH INFORMATION (Patients under 16)

Father's Height ______Mother's Height ___________Patient resembles: Father __Mother __Neither __Adopted__
Any recent growth? _____When and how much ?____
Girls: Has she started menstruation? Yes No When?____
Boys: Has his voice changed? Yes No When?____

DENTAL HISTORY

Yes No Any injuries to the face, mouth, or teeth?
Explain____
Yes No Has the patient ever sucked a thumb or finger? Until what age?____
Yes No Any history of jaw joint soreness, clicking, or popping?____
Yes No Any history of clenching or grinding of teeth?____
Yes No Has an orthodontist been consulted previously?
When?____
Yes No Has the patient had any previous orthodontic treatment?
When?____
Why are you seeking orthodontic consultation? (What is your main concern?)______________________________
____
Any additional information which you feel would help make your association with us more enjoyable.
____
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RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper orthodontic care.
I authorize release of any information concerning my (or my child's) orthodontic care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) orthodontic care, advice and treatment to my dentist and/or referred specialist.
I hereby authorize payment of insurance benefits directly to Ted Vossers, DDS, MS, PA otherwise payable to me.
I understand that my orthodontic care insurance carrier or payor of my orthodontic benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.
I authorize your office and/or a collection agency to contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
I/We have read this disclosure and agree that the business providing service may contact me/us as described above.
I/We understand that there is a $25 fee if a check is returned from the bank.

Patient's or Guardian's
Signature____________________________________Date_____________________________________

Witness Signature______________________________