

Welcome to



Hudson & Axelrod
ORTHODONTICS

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We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____ Male Female
Child's Name: _____
Nickname: _____ Child's Age: _____
Child's Birthdate: ___/___/___ Teacher: _____
School: _____ Grade: _____
Hobbies / Sports: _____
Child's Home #: (____) _____
Child's Home Address: _____

APT/CONDO # _____

2 Who Is Accompanying Your Child Today?

Name: _____ Relation: _____
Do you have legal custody of this child? Yes No
Whom may we thank for referring you? _____
List brothers / sisters with age: _____

General Dentist: _____
Last Visit Date: _____
Parent's Marital Status: Single Widowed
 Married Divorced Separated

3 Mother's Information Step Mother Guardian

Name: _____
Wk#: (____) _____ Ext: _____ Hm #: (____) _____
Employer: _____
How Long at Current Job: _____ Job Title: _____
SS #: _____ Date of Birth: ___/___/___

Father's Information Step Father Guardian

Name: _____
Wk#: (____) _____ Ext: _____ Hm #: (____) _____
Employer: _____
How Long at Current Job: _____ Job Title: _____
SS #: _____ Date of Birth: ___/___/___

4 Person Responsible for Account

Name: _____ Relation: _____
Billing Address: _____

CITY STATE ZIP
Previous Address: _____

CITY STATE ZIP
Wk #: (____) _____ Ext: _____ Hm #: (____) _____
Employer: _____
SS #: _____ DL#: _____

Who is Responsible for Making Appointments?

Name: _____
Wk #: (____) _____ Ext: _____ Hm #: (____) _____

5 Primary Insurance Information

Orthodontic Coverage? Yes No
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____) _____
Group Plan # (Plan, Local, or Policy#): _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: ___/___/___ SS #: _____
Policy Owner's Employer: _____

Secondary Insurance Information

Orthodontic Coverage? Yes No
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____) _____
Group Plan # (Plan, Local, or Policy#): _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: ___/___/___ SS #: _____
Policy Owner's Employer: _____

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

Has your child ever been evaluated or had orthodontic treatment before? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

List any musical instruments played: _____

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

Has your child ever had any pain / tenderness in his/her jaw joint (TMJ / TMD)? Yes No

Does your child brush his/her teeth daily? Yes No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is your child currently under the care of a physician? Yes No

Has puberty begun? Yes No

Has menstruation begun? (Girls) Yes No

Please describe your child's current physical health:
 Good Fair Poor

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

Please list all drugs that your child is allergic to: _____

7 Has your child ever had any of the following medical problems?

- | | |
|--------------------------------|-------------------------------|
| Y N Abnormal Bleeding | Y N Diabetes |
| Y N Allergies | Y N Handicaps / Disabilities |
| Y N Allergic to Latex / Metals | Y N Hearing Impairment |
| Y N Allergic to Plastic | Y N Heart Murmur |
| Y N Any Hospital Stays | Y N Hemophilia |
| Y N Any Operations | Y N Hepatitis |
| Y N Asthma | Y N HIV+ / AIDS |
| Y N Cancer | Y N Kidney / Liver Problems |
| Y N Congenital Heart Defect | Y N Rheumatic / Scarlet Fever |
| Y N Convulsions / Epilepsy | Y N Tuberculosis |

Please discuss any medical problems that your child has had:

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

- | | |
|--------------------------------|----------------------------|
| Y N Clenching / Grinding Teeth | Y N Nursing Bottle Habits |
| Y N Lip Sucking / Biting | Y N Speech Problems |
| Y N Mouth Breather | Y N Thumb / Finger Sucking |
| Y N Nail Biting | Y N Tongue Thrust |

9 Neighbor or Relative not living with you

Name: _____ Phone #: (____) _____

Address: _____

CITY

STATE

ZIP

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize payment to my attending Orthodontist. I understand that am financially responsible for any charges not covered by this authorization. I also authorize release of any information relating to claims. I understand that, where appropriate, credit bureau reports may be obtained.

SIGNATURE OF PARENT OR GUARDIAN

DATE

Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDS and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein.

Doctors Comments:

Initials: _____ Date: _____

Initials: _____ Date: _____
