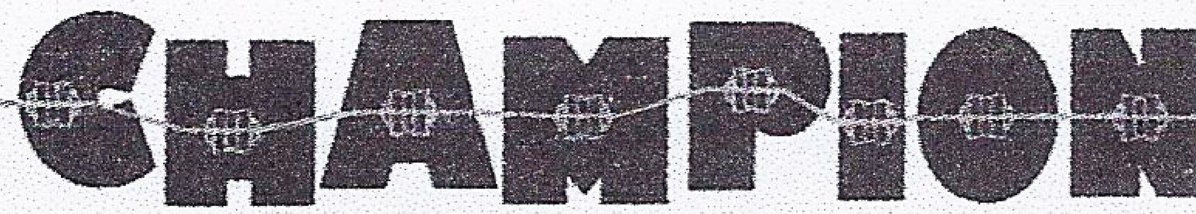

Orthodontics

A Professional Dental Corporation

Ronald L. Champion, D.D.S., M.S.D.
Board Certified Orthodontic Specialist
4101 Tully Road • Suite 401
Modesto, California 95356

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:________________ Nickname:____________________

Child's Name:____
LAST FIRST M

Email Address:____________________ SS#:_______________

Birthdate:____/____/____ Age:________ ❑ Male ❑ Female

School:____________________ Grade:___________

Hobbies / Sports:___________________________________

Child's Home # (   )________________________________

Child's Home Address:_______________________________
APT/CONDO #

____
CITY STATE ZIP

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 ages:____________________

____

General Dentist: ____________________________________

Last Visit Date: ____________________________________

Parents Marital Status: ❑ Married ❑ Separated ❑ Widowed
❑ Single ❑ Partnered ❑ Divorced

3 ❑ Mother's Information ❑ Step Mother ❑ Guardian

Name: ______________________ Birthdate: ____/____/____

Wk #: (   )______________ Ext: ____ Hm # (   )______________

Employer: ____

How Long at Current Job: _____ Job Title: ________________

SS#:______________________ DL #:______________________

❑ Father's Information ❑ Step Father ❑ Guardian

Name: ______________________ Birthdate: ____/____/____

Wk #: (   )______________ Ext: ____ Hm # (   )______________

Employer: ____

How Long at Current Job: _____ Job Title: ________________

SS#:______________________ DL #:______________________

4 Person Responsible For Account

Name:______________________________ Relation :______________

Child's Name:____
APT/CONDO #

____
CITY STATE ZIP

Previous Address: ___________________________________
APT/CONDO #

____
CITY STATE ZIP

Wk #: (   )______________ Ext: ____ Hm # (   )______________

SS #______________________ DL # ______________________

Employer: ____

Who is responsible for making appointments.

Name: ____

Wk #: (   )______________ Ext: ____ Hm # (   )______________

5 Primary Orthodontic Insurance

Orthodontic Coverage ❑ Yes ❑ No

Insurance Co Name:___________________________________

Insurance Co. Address: _______________________________

Insurance Co. Phone # (   ) ___________________________

Group 3 (Plan, Local or Policy #):______________________

Policy Owner's Name: ________________________________

Relationship to Patient:_______________________________

Policy Owner's Birthdate: ____/____/____ ID #: ______________

Policy Owner's Employer:______________________________

Employer's Address:__________________________________

Secondary Orthodontic Insurance

Orthodontic Coverage ❑ Yes ❑ No

Insurance Co. Name: _________________________________

Insurance Co. Address: _______________________________

Insurance Co. Phone # (   ) ___________________________

Group 3 (Plan, Local or Policy #):______________________

Policy Owner's Name: ________________________________

Relationship to Patient:_______________________________

Policy Owner's Birthdate: ____/____/____ ID #: ______________

Policy Owner's Employer:______________________________

Employer's Address:__________________________________

CONTINUED ON BACK

6

What are the main concerns that you would like orthodontic treatment to correct?

____

____

Has you child ever taken Phen-Fen? ❑ Yes ❑ No
(Also known as Redux or Pondimin) If yes, when?__________

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 on 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

Floss 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 / things that your child is allergic to: __________

____

____

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

Y N Abnormal Bleeding	Y N Convulsions / Epilepsy
Y N ADD / ADHD	Y N Diabetes
Y N Allergies to any Drugs	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 Artificial Bones / Joints / Valves	Y N HIV / AIDS
Y N Asthma	Y N Kidney / Liver Problems
Y N Cancer	Y N Lupus
Y N Congenital Heart Defect	Y N Rheumatic / Scarlet Fever
	Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

____

____

____

8 Has your child ever experienced any of the following?

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

Neighbor or Relative not living with you:

Name__________ Phone: ( )__________

Address: __________
APT/CONDO #

____
CITY STATE ZIP

9

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

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use one or more credit reporting services.

Signature: __________

I authorize the dental staff to perform any necessary dental services my child may need.

____
Signature of parent or guardian Date

If this office accepts insurance, I understand that am responsible for payment of services rendered also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office

Signature: __________

The Parent or Guardian who accompanies the child is responsible for payment.
Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials: __________ Date: __________

Doctor's Comments: __________

____

____

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