WELCOME!

We would like to welcome you to the office of Dr. Harold A. Fleming!
Our staff is devoted to providing exceptional orthodontic care, please let us know if there is anything we can do to make your child more comfortable during treatment!

CHILD INFORMATION

Tell us about your child

Name_________________________________ Nickname ______________________ Sex: M / F

Address_____________________________________ Zip_____________ Phone _______________

E-mail Address________________________________ SS#________________________

School ____________________________ Grade _________ Birth date _____________Age ________

Hobbies / Sports____

Do you have any relatives that we've seen in our office before? ________________________________

Names: ____

What is your primary concern for today's visit? ____

____

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

Do you have legal custody of this child? ☐ Yes ☐ No

FAMILY INFORMATION

FATHER ☐ **Step Father** ☐ **Guardian**

Name__________________________________
_
Address________________________________
_
____

Work phone______________________________
Cell phone________________________________
Date of birth_____________________________
Social Security #___________________________
Employer________________________________
How long at current job? ____________________
Job Title________________________________

MOTHER ☐ **Step Mother** ☐ **Guardian**

Name__________________________________

Address________________________________

____

Work phone______________________________
Cell phone________________________________

Date of birth_____________________________
Social Security #___________________________

Employer________________________________
How long at current job? ____________________
Job Title________________________________

Are parents: single married divorced separated

Person responsible for account____
EMERGENCY contact ________________________________ Phone________________________

Responsible party signature____________________________________ Date_________________

PERSON RESPONSIBLE FOR ACCOUNT

Name_______________________________________ Relation to child _____________________

Home Address____

Zip_____________

Billing Address (if different from Home)____

Zip____________ Home Phone ________________ Work Phone_________________ Ext.

_____

E-mail Address______________________________ SS#_______________________

Who is responsible for making appointments?

Name ____

Work Phone_____________________ Ext.____________ Home phone_____________________

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage ☐ Yes ☐ No

Insurance Co. Name____

Insurance Co. Address____

Insurance Co. Phone ____

Group # (Plan, Local, or Policy #) ____

Policy Owner's Name____

Relationship to Patient____

Policy Owner's Birth date______________________ SS#_________________________________

Policy Owner's Employer? ____

Employers Address____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature of parent or guardian __________________________________ Date _________________

CHILD'S HEALTH HISTORY

Is your child in good health? ☐ Yes ☐ No - If No, please explain__________________________________

Name of Physician____

Has your child been hospitalized or had operations? ☐ Yes ☐ No - If Yes, please explain

____

Has your child had tonsils and/or adenoids removed? ☐ Yes ☐ No

Is your child currently taking any medications? ☐ Yes ☐ No - If Yes, please describe what medications are being taken, and for what purpose____

Has your child begun puberty? ☐ Yes ☐ No - If Yes, at what age? _______________________________

For Girls: has menstruation begun? ☐ Yes ☐ No

Does your child have seasonal or environmental allergies? ☐ Yes ☐ No - If yes, please explain____

Does your child have frequent colds, sore throat, ear infections? ☐ Yes ☐ No - If Yes, please explain____

Does your child have frequent headaches or muscle soreness around the head and neck? ☐ Yes ☐ No - If yes, how do you treat the pain?

____

Does your child have allergies to any of the following?

Aspirin ☐ Yes ☐ No	Latex ☐ Yes ☐ No	Tetracycline ☐ Yes ☐ No
Codeine ☐ Yes ☐ No	Metals/Nickel ☐ Yes ☐ No	Other ☐ Yes ☐ No
Anesthetics ☐ Yes ☐ No	Penicillin ☐ Yes ☐ No	
Erythromycin ☐ Yes ☐ No	Plastics ☐ Yes ☐ No	

If Yes, please describe____

Has your child had any rods, pins, implants, artificial heart valves, etc.? ☐ Yes ☐ No

Has your child been diagnosed or treated for any of the following? (please circle)

ADD/ADHD
Aids
Arthritis
Asthma
Blood disorder
Blood transfusion
Breathing problems
Cancer/chemotherapy
Congenital heart defects
Convulsions/seizures
Diabetes
Endocrine disorders

Epilepsy
Fainting
Frequent headaches
Heart murmur
Heart surgery, pacemaker, etc.
Hepatitis
Herpes
High blood pressure
Low blood pressure
Mitral valve prolapse
Pneumonia
Rheumatic fever
Scoliosis
Seasonal/environmental allergies
Sinusitis
Thyroid problems
Tuberculosis
Venereal disease

Please list other medical conditions, and explain above conditions___________________________________

____

CHILD'S DENTAL HISTORY

Name of

Dentist____

Date of last dental examination______________________

Has your child had any injuries to the face, mouth or teeth? ☐ Yes ☐ No - If Yes, please

explain________

____

Has your child ever sucked his/her fingers or thumb? ☐ Yes ☐ No - If Yes, until what age? ____________

Has your child ever had a speech problem? ☐ Yes ☐ No – if Yes, has your child ever had speech therapy?

☐ Yes ☐ No – If Yes, over what ages? _______________________

Does your child breathe primarily through his/her mouth? ☐ Yes ☐ No

Does your child ever clench or grind his/her teeth? ☐ Yes ☐ No - If Yes, please explain_______________

Has your child ever had clicking, popping or pain in his/her jaw joints or chewing muscles on opening or closing the mouth? ☐ Yes ☐ No - If Yes, please explain____

____

I understand that the information that I have given above is correct to the best of my knowledge, that it will be held with the utmost confidentiality and it is my responsibility to inform Dr. Fleming and team of any changes in my child's medical status.

Signature____Date______________________

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Thank you for taking the time to provide us with the above information!