



MICHAEL P. MEEHAN, D.D.S., M.C.I.D., P.C.

Specialist in Orthodontics

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.

TELL US ABOUT YOUR CHILD

Date: Child's name: SS#: Nickname: Child's birthdate: Child's age: School: Grade: Hobbies/sports: Child's home #: Child's home address: City: State: Zip:

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: Relation: Do you have legal custody of this child: Whom may we thank for referring you? List brothers/sisters w/age: General dentist: Last visit date: Parents marital status: Single Widowed Married Divorced Separated

MOTHER'S INFORMATION

Mother Step Mother Guardian Name: Work #: Ext.: Home #: Employer: SS#: DL#:

FATHER'S INFORMATION

Father Step Father Guardian Name: Work #: Ext.: Home #: Employer: SS#: DL#:

PERSON RESPONSIBLE FOR ACCOUNT

Name: Relation: Billing address: City: State: Zip: Work #: Ext.: Home #: Employer: # yrs. employed: SS#: DL#:

E-MAIL ADDRESS

Name: E-mail Address:

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage: Yes No Insurance Co. name: Insurance Co. address: Insurance Co. phone #: Group # (plan, local or policy #): Insured's name: Relation: Insured's birthdate: SS#: Insured's employer:

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage: Yes No Insurance Co. name: Insurance Co. address: Insurance Co. phone #: Group # (plan, local or policy #): Insured's name: Relation: Insured's birthdate: SS#: Insured's employer:

Form Continued On Back

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 instruments played: _____

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing teeth 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

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: _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- | | |
|---------------------------|------------------------------|
| Y N Allergic to plastic | Y N Allergic to latex/metals |
| Y N Heart murmur | Y N Congenital heart defect |
| Y N Cancer | Y N Convulsions/epilepsy |
| Y N Diabetes | Y N Abnormal bleeding |
| Y N Rheumatic fever | Y N Hearing impairment |
| Y N HIV+/AIDS | Y N Any operations |
| Y N Hemophilia | Y N Any stays in a hospital |
| Y N Asthma | Y N Kidney/liver problems |
| Y N Hepatitis/jaundice | Y N Handicaps/disabilities |
| Y N Tuberculosis (TB) | Y N Allergies to any drugs |
| Y N Blood transfusion | Y N Wears contact lenses |
| Y N Eye problems/glaucoma | Y N Thyroid disease |
| Y N High blood pressure | Y N Stomach ulcer |
| Y N Anemia | Y N Chronic cough |

Please discuss any medical problems that your child has had:

Name of relative not living with you that we may contact in case of emergency: _____

Phone #: _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

- | | |
|------------------------------|--------------------|
| Y N Thumb/finger sucking | Y N Mouth breather |
| Y N Lip sucking/biting | Y N Nail biting |
| Y N Clenching/grinding teeth | Y N Tongue thrust |
| Y N Nursing bottle habits | |

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 child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian

Date

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

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

Signature of Parent or Guardian

Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein, Initials _____ Date _____

Doctor's Comments: _____