Meehan ORTHODONTICS

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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: _____
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: ❑ Yes ❑ No
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#: _____ CELL#: _____

FATHER'S INFORMATION

❑ Father ❑ Step Father ❑ Guardian
Name: _____
Work #: _____ Ext.: _____ Home #: _____
Employer: _____
SS#: _____ CELL#: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
Billing Address: _____
City: _____ State: ___ Zip: _____
Work #: _____ Ext .: _____ Home #: _____
Employer: _____ # yrs. employed: _____
SS#: _____ CELL #: _____

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 ☞

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meehanorthodontics.com

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 (T8)	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: _____

_____