ORTHODONTICS by DR. BURSON

CHILD FORM

STACEE BURSON, D.M.D., M.S.
(903) 334-8080
5508 COWHORN CREEK RD
TEXARKANA, TX 75503

Our goal is to help your child reach and maintain good oral health and a beautiful smile that lasts a lifetime.

TELL US ABOUT YOUR CHILD

Today's Date: _____ Nickname: _____

Child's Name: _____ ☐ M ☐ F
Last First Middle

Date of Birth: _____ Age: _____ SSN: _____

Home Address: _____
Street City Zip

School: _____ Grade: _____

Hobbies / Sports: _____

Home Phone: _____

Email Address: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Y ☐ N

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Date of Last Visit: _____

Parent's Marital Status: ☐ Single ☐ Partnered ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

PARENT / GUARDIAN INFORMATION

☐ Mother ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: _____

Employer: _____

Work Phone: _____ Home: _____

Years Employed: _____ Job Title: _____

SSN: _____ DL No.: _____

☐ Father ☐ Step Father ☐ Guardian

Name: _____ Birthdate: _____

Employer: _____

Work Phone: _____ Home: _____

Years Employed: _____ Job Title: _____

SSN: _____ DL No.: _____

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: _____ Phone No.: _____

Address: _____
Street City Zip

PERSON RESPONSIBLE FOR ACCOUNT

Work Phone: _____ Home Phone: _____

Billing Address: _____

Relation: _____ SSN: _____

Employer _____ Drivers License No.: _____

ORTHODONTIC INSURANCE

PRIMARY

Orthodontic Coverage: ☐ Y ☐ N Dental Coverage: ☐ Y ☐ N

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone No.: _____

Group No. (Plan, Local or Policy No.): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID No.: _____

Insured's Employer: _____

SECONDARY

Orthodontic Coverage: ☐ Y ☐ N Dental Coverage: ☐ Y ☐ N

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone No.: _____

Group No. (Plan, Local or Policy No.): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID No.: _____

Insured's Employer: _____

DENTAL & MEDICAL HISTORY

What would you like orthodontics to accomplish? _____

_____

Has your child ever taken Phen-Fen (Redux or Pondimin)? ☐ Y ☐ N

If "Yes", when? _____

Has your child ever had or been evaluated for orthodontic treatment? ☐ Y ☐ N

Has your child ever had an injury to their: ☐ Mouth ☐ Teeth ☐ Chin

List any musical instruments played: _____

Has your child had adenoids or tonsils removed? ☐ Y ☐ N

Do your child have any missing or extra permanent teeth? ☐ Y ☐ N

Has your child ever experienced pain / discomfort in their jaw joint (TMJ / TMD)? ☐ Y ☐ N

CONTINUED ON BACK

DENTAL & MEDICAL HISTORY *(CONTINUED)*

Does your child brush their teeth daily? ☐Y ☐N

Does your child floss their teeth daily? ☐Y ☐N

Child's Physician: _____

Phone No.: _____ Date of last visit: _____

Is your child under the care of a physician? ☐Y ☐N

Has puberty begun? ☐Y ☐N

Girls - Has menstruation begun? ☐Y ☐N

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

Please list all drugs your child is currently taking: _____

_____

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

☐Y ☐N	Abnormal Bleeding	☐Y ☐N	Diabetes
☐Y ☐N	ADD / ADHD	☐Y ☐N	Handicaps / Disabilities
☐Y ☐N	Allergies to Any Drugs	☐Y ☐N	Hearing Impairment
☐Y ☐N	Allergic to Latex / Metals	☐Y ☐N	Heart Murmur
☐Y ☐N	Allergic to Plastic	☐Y ☐N	Hemophilia
☐Y ☐N	Any Hospital Stays	☐Y ☐N	Hepatitis
☐Y ☐N	Any Operations	☐Y ☐N	HIV+ / AIDS
☐Y ☐N	Artificial Bones / Joints / Valves	☐Y ☐N	Hospitalized for Any Reason
☐Y ☐N	Asthma	☐Y ☐N	Kidney / Liver Problems
☐Y ☐N	Cancer / Chemotherapy	☐Y ☐N	Lupus
☐Y ☐N	Congenital Heart Defect	☐Y ☐N	Rheumatic / Scarlet Fever
☐Y ☐N	Convulsions / Epilepsy	☐Y ☐N	Tuberculosis (TB)

Please discuss any serious medical condition(s) that your child has ever had: _____

_____

_____

Are you allergic to any of the following?

☐Y ☐N	Aspirin	☐Y ☐N	Latex
☐Y ☐N	Codeine	☐Y ☐N	Penicillin
☐Y ☐N	Metals / Plastics	☐Y ☐N	Tetracycline
☐Y ☐N	Dental Anesthetics	☐Y ☐N	Other
☐Y ☐N	Erythromycin		

If other, please list here: _____

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

Please list any other drug/ material allergies: _____

_____

_____

INFORMED CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

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 the services of one or more credit reporting services.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

If this office accepts insurance, 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. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

The Parent or Guardian who accompanies the child is responsible for payment.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

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

Doctor's Comments: _____

_____

_____

_____

_____