MOSES ORTHO

Tell Us About Your Child

Today's Date: _____/_____/_____
Patient's Name:_____
Patient's Birthdate:____/_____/_____ ☐Male ☐Female
Email Address: _____
School:_____Grade:_____
Hobbies/Sports:_____
Patient's Home #: (_____)_____
Patient's SS #:_____
Patient's Home Address:_____
_____

General Information

Who is accompanying the child today?
Name:_____Relation:_____
Do you have legal custody of this child? ☐Yes ☐No
Whom may we thank for referring you?
_____
General Dentist: _____
Last visit date:_____ Dentist's Phone:_____
Other siblings/ages:_____
_____

Parent's Information

Who is responsible for account? _____
Parent's Marital Status: ☐Single ☐Married ☐Partnered ☐Widowed ☐Divorced ☐Separated

☐Father ☐Step-Father ☐Guardian
Name:_____Birthdate___/___/___
Address: (If different than patient's) Home#(____) _____
_____
_____
SS#: _____ DL#: _____
Wk #: (____)_____ Cell #:(____)_____
Email:_____
Employer:_____Occupation:_____
Employer's Address_____
_____
If you have Orthodontic Insurance Coverage for the patient, please fill out below:

Insurance Co. Name: _____
Insurance Address: _____
_____
Insurance Phone: (____)_____Insured's ID#:_____
Group# (Plan, Local, or Policy #): _____

☐Mother ☐Step-Mother ☐Guardian
Name:_____Birthdate___/___/___
Address: (If different than patient's) Home#(____) _____
_____
_____
SS#: _____ DL#: _____
Wk #: (____)_____ Cell #:(____)_____
Email:_____
Employer:_____Occupation:_____
Employer's Address_____
_____
If you have Orthodontic Insurance Coverage for the patient, please fill out below:

Insurance Co. Name: _____
Insurance Address: _____
_____
Insurance Phone: (____)_____Insured's ID#:_____
Group# (Plan, Local, or Policy #): _____

Authorization

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 this office, use the services of one or more credit reporting services. 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 the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian _____ Date _____

16600 SE 15th St. Ste A
Vancouver, WA 98683

360.514.0055
mosesorthodontics.com

Dental & Medical History

What are the main concerns that you would like orthodontics to accomplish? _____

_____

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

Have there been any injuries to the face, mouth, teeth or chin? ☐Y ☐N

Does your child require antibiotics before dental treatment? ☐Y ☐N

Have adenoids or tonsils been removed? ☐Y ☐N

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

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐Y ☐N

Does your child brush his/her teeth daily? ☐Y ☐N

Floss his/her teeth daily? ☐Y ☐N

Patient's Physician: _____

Phone#: _____Date of last visit:_____

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

Has puberty begun? ☐Y ☐N

Has menstruation begun? ☐Y ☐N

Please describe your child's current physical health:

☐Good ☐Fair ☐Poor

Please list all drugs that your child is currently taking:

_____

_____

Aside from items listed below, list all drugs/things your child is allergic to:

_____

_____

_____

☐Y ☐N Latex ☐Y ☐N Nickel/Metals ☐Y ☐N Plastic

Has your child experienced the following medical problems?

☐Y ☐N Abnormal Bleeding
☐Y ☐N ADD/ADHD
☐Y ☐N AIDS/HIV+
☐Y ☐N Hospital Stays/ Operations
☐Y ☐N Artificial Bones/ Joints/Valves
☐Y ☐N Asthma
☐Y ☐N Cancer
☐Y ☐N Congenital Heart Defect
☐Y ☐N Convulsions
☐Y ☐N Diabetes
☐Y ☐N Epilepsy
☐Y ☐N Hearing Impairment
☐Y ☐N Heart Murmur
☐Y ☐N Hemophilia
☐Y ☐N Hepatitis
☐Y ☐N Kidney Problems
☐Y ☐N Liver Problems
☐Y ☐N Mitral Valve Prolapse
☐Y ☐N Prosthetics
☐Y ☐N Rheumatic Fever
☐Y ☐N Scarlet Fever
☐Y ☐N Sickle Cell Disease/ Traits
☐Y ☐N Tuberculosis (TB)
☐Y ☐N Handicaps/ Disabilities

Has your child ever taken any diet pills such as Phen-Fen (Also known as Redux or Pondimin)? ☐Y ☐N

If so, when? _____

Are your child's immunizations current ☐Y ☐N

Anything you would like to discuss with the Doctor in private? ☐Y ☐N

Please discuss any serious medical problems your child has had:

_____

_____

Does/did your child experience any of the following?

☐Y ☐N Breast Fed
☐Y ☐N Clenching/Grinding Teeth
☐Y ☐N Lip Sucking/Biting
☐Y ☐N Mouth Breather
☐Y ☐N Nail Biting
☐Y ☐N Nursing Bottle Habits
☐Y ☐N Speech Problems
☐Y ☐N Thumb/Finger Sucking
☐Y ☐N Tongue Thrust
☐Y ☐N Used Pacifier

List any musical instruments played:_____

_____

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.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

Signature of Parent or Guardian _____ Date _____