Welcome to Manfred Orthodontics

We would like to welcome you and your child to our office. Please fill out this form completely. The better we communicate, the better we can care for you.

About Your Child

Today's Date: ______________________________

Child's Name: ______________________________

Nickname: _________________________

__ Male __ Female

Child's Birth Date: __/___/___ Age:_____________

Home Address: ____________________________

____

Home #:_________________________________

Child's School: ____________________________

Other family members seen by us:

____

Whom may we thank for referring you?:_____________________________________

Child's Dentist: ____________________________

Last Visit Date: ____________________________

Mother's Information

Name:__________________Relation: ___________

___ Married ___Divorced ___ Widowed

Employer: _________________________________

Occupation: _______________________________

BirthDate: ___/___/___

Contact #: _________________________________

Primary Contact Email: _______________________

Father's Information

Name: ________________ Relation: ___________

___Married ___Divorced ___ Widowed

Employer: _________________________________

Occupation: _______________________________

BirthDate: ___/___/____

Primary Orthodontic Insurance

Orthodontic Coverage: __Yes __No __ Don't Know

Insurance Co. Name: __________________________

Insurance Co. Address: ________________________

Insurance Co. Ph Number: ______________________

Group #: ____________________________________

Insured's Name: ______________________________

Relationship to Parent: _________________________

Insured's Birth Date: _____/_____/_______

Insured's ID or SS#: ___________________________

Insured's Employer: ____________________________

Secondary Orthodontic Insurance

Orthodontic Coverage: __Yes __No __ Don't Know

Insurance Co. Name: __________________________

Insurance Co. Address: ________________________

Insurance Co. Ph Number: ______________________

Group #: ____________________________________

Insured's Name: ______________________________

Relationship to Parent: _________________________

Insured's Birth Date: _____/_____/_______

Insured's ID or SS#: ___________________________

Insured's Employer: ____________________________

What are the Main Concerns that you would like Orthodontics to Address?

____

____

____

____

____

____

____

Your Child's Medical History

Child's Physician's Name: ________________________

Phone #: _____________ Date of Last visit: ________

Please list all prescription drugs your child is taking:

____

____

Does your child have any known allergies?: ___Y __N

Please list:

____

____

Please list any serious medical conditions or hospital stays that your child has ever had:

____

____

Your Child's Dental History

Has your child ever had or been evaluated for orthodontic treatment?: ___Y ____N

Has your child had any injuries to the face, mouth, or jaws? _____Y _____N

Has your child ever had any pain or tenderness in his/her jaw joint? (TMD): ____ Y _____N

Does your child have any thumb sucking or tongue thrusting habits? ____Y ____N

Does your child brush and floss daily?: ___Y ___N

Does your child have any speech problems?: ___Y ___N

Does your child clench or grind his/her teeth?: ___Y ___N

Does your child have any missing or extra permanent teeth that you know of?: ____ Y _____N

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

Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes/Tuberculosis
Y N Difficult Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures
Y N Fever Blisters/Herpes
Y N Handicaps/Disabilities
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV/AIDS
Y N Hospitalizations
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers/Colitis

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.

Signed: ________________________________

Date: __________________________________

OFFICE USE ONLY:

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor Signature: ________________________

Date: __________________________________

MANFRED
ORTHODONTICS
LAUREN N MANFRED, DDS, MS