FRED PIPER, D.D.S., M.S., P.C.

Orthodontics & Dentofacial Orthopedics

Expertise in Dental Molding

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.

1. TELL US ABOUT YOUR CHILD

Today's Date:_____/_____/_____ ☐ Male ☐ Female

Child's Name: ______________________________
Last First MI

Nickname ______________________________

Child's Birthdate:_____/_____/_____ Child's Age: __________

School:____________________ Grade: __________

Hobbies / Sports: ______________________________

Child's Home #: (_____) ______________________________

Child's Home Address: ______________________________
Apt / Condo #

____
City State Zip

2. 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? ______________________________

Other family members seen by us:______________________________

____

General Dentist: ______________________________

Address:______________________________

____
City State Zip

Last Visit Date: ______________________________

3. Mother's Information:

Responsible for Account ☐ Yes ☐ No

Name: ______________________________

Home Address: ______________________________

____
City State Zip

Hm #: (_____)__________ Cell #:(_____)__________

Employer: ______________________________

Wk #:(_____)__________ Ext._____ SS #:__________

☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

4. Father's Information:

Responsible for Account ☐ Yes ☐ No

Name: ______________________________

Home Address: ______________________________

____
City State Zip

Hm #: (_____)__________ Cell #:(_____)__________

Employer: ______________________________

Wk #:(_____)__________ Ext._____ SS #:__________

☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

5. Primary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: (_____) ______________________________

Group # (Plan, Local, or Policy #): ______________________________

Policy Owner's Name:______________________________

Address:____________________ Phone #:__________

Relationship to Patient: ______________________________

Policy Owner's Birthday: ___/___/___ SS#: __________

Policy Owner's Employer: ______________________________

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: (_____) ______________________________

Group # (Plan, Local, or Policy #): ______________________________

Policy Owner's Name:______________________________

Address:____________________ Phone #:__________

Relationship to Patient: ______________________________

Policy Owner's Birthday: ___/___/___ SS#: __________

Policy Owner's Employer: ______________________________

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6. What are the main concerns that you would like orthodontics to accomplish? ______

Has you 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 musical instruments played: ______

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does you 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

Has menstruation begun? (Girls) ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

(Also known as Redux or Pondimin) If yes, when? ______

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/things that your child is allergic to: ______

______

7. Has your child ever had any of the following 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	Kidney Problems
Y	N	Asthma	Y	N	Liver Problems
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Sickle Cell Disease / Traits
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

______

______

______

______

8. Does / did your child have any of the following habits?

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

9. 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 authorize the dental staff to perform the necessary dental services my child may need.

______

Signature of parent or guardian Date

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.

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

Initials:______ Date:______

Doctor's Comments: Class______

______

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