Piper Orthodontics

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Fred Piper DDS, MS, PC
Specialist in Orthodontics

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

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name:_____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Other family members seen by us:_____

_____

General Dentist: _____

Address:_____

_____
City State Zip

Last Visit Date: _____

2. How did you hear about our practice?

☐ Referred by Dentist

(If yes, who?) _____

☐ Existing Patient

(If yes, who?) _____

☐ Internet Search

☐ Other _____

3. Mother's Information:

Responsible for Account ☐ Yes ☐ No

Name: _____

Home Address: _____

_____
City State Zip

Hm #:(____)_____ Cell #:(____) _____

Employer: _____

Wk #:(____)_____ Ext._____ Hm #: (_____) _____

☐ Single ☐ Widowed ☐ Maried ☐ Divorced ☐ Separated

Family Email: _____

4. Father's Information:

Responsible for Account ☐ Yes ☐ No

Name: _____

Home Address: _____

_____
City State Zip

Hm #:(____)_____ Cell #:(____) _____

Employer: _____

Wk #:(____)_____ Ext._____ Hm #: (_____) _____

☐ Single ☐ Widowed ☐ Maried ☐ Divorced ☐ Separated

Family Email: _____

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: _____

CONTINUED ON BACK

6. Dental History

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

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

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 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

Has menstruation begun? (Girls) ☐ 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/things that your child is allergic to: _____

_____

_____

7. Medical History

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	Heat 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. Oral Habits

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 staff to perform the necessary orthodontic services my child may need.

_____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at the time services are rendered.

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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_____

_____

_____

_____

_____

_____

_____

_____

Piper Orthodontics

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/ video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for: Social Media, Website, and/or Advertising. The information will only be used for Piper Orthodontics communications.

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing. Revocation affects disclosure moving forward and is not retroactive.

No Treatment Conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

If desired, copy provided:

⚪Yes, I would like a copy of this form." (initialed by team member, copy provided by _____)

Patient Name:_____ **Date:**_____

Signature:_____

If Patient is a Minor

Name:_____ **Date:**_____

Parent/Legal Guardian

Signature:_____ **Date:**_____

Practice Name: Piper Orthodontics

Signature:_____ **Date:**_____