Susan M Lempert, DMD MS
ORTHODONTIST

Welcome to the Orthodontist

Today's Date: _____

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below.

Child's Name: _____Nickname:_____
LAST FIRST MI

□Male □Female Child's Birth date: ___/___/_____ Child's Age: _____ Hm #:_____

Child's Home Address: _____
APT/ CONDO # CITY STATE ZIP

School: _____

Hobbies / Sports: _____

Who is accompanying your child today? Name: _____

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

Whom may we **Thank** for referring you? _____

List brothers / sisters with age: _____

General Dentist: _____Last Visit Date:_____

Parent's Marital Status: □Single □Married □Divorced □Widowed □Separated

Mother's Information □Stepmother □Guardian Hm #:_____

Name: _____ SS #:_____Birth date: ___/___/_____

Employer:_____Wk #:_____Ext:_____

How long at the current job:_____ Job Title: _____

Father's Information □Stepfather □Guardian Hm #:_____

Name: _____ SS #:_____Birth date: ___/___/_____

Employer:_____Wk #:_____Ext:_____

How long at the current job:_____ Job Title: _____

Person Responsible for Account:_____SS #:_____

Billing Address:_____

Relation:_____Wk #:_____Ext:_____Hm #:_____

Employer:_____

ORTHODONTIC INSURANCE – Primary

Orthodontic Coverage: □Yes □No Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone Number:_____Group # (Plan, Local or Policy #):_____

Policy Owner's Name:_____ Relation:_____

Policy Owner's Birthdate: ___/___/_____ Policy Owner's SS #:_____

Policy Owner's Employer:_____

(Continue on Back)

ORTHODONTIC INSURANCE – Secondary

Orthodontic Coverage: □Yes □No Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone Number:_____Group # (Plan, Local or Policy #):_____

Policy Owner's Name:_____ Relation:_____

Policy Owner's Birthdate: ___/___/_____ Policy Owner's SS #:_____

Policy Owner's Employer:_____

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

_____

Has your child ever been evaluated for orthodontic treatment?□Yes □No

Has there ever been any injury to your child's: □Mouth □Teeth □Chin

Have adenoids or tonsils been removed?□Yes □No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	HIV+/ AIDS
Y	N	Allergies to any Drugs	Y	N	Kidney/ Liver Problems
Y	N	Allergies to Latex/Metals	Y	N	Rheumatic / Scarlet Fever
Y	N	Asthma	Y	N	Tuberculosis
Y	N	Cancer/Chemotherapy	Y	N	Clenching/ Grinding Teeth
Y	N	Congenital Heart Defect	Y	N	Lip Sucker/ Biting
Y	N	Convulsion/ Epilepsy	Y	N	Mouth Breathing
Y	N	Diabetes	Y	N	Nail Biting
Y	N	Hearing Impairment	Y	N	Speech Problems
Y	N	Heart Murmur	Y	N	Thumb/ Finger Sucking
Y	N	Hepatitis	Y	N	Tongue Thrust

Please discuss any medical problem that your child has had: _____

Is your child currently under the care of a physician? □Yes □No Date of Last Visit: _____

Child's Physician Name: _____ _____Phone #:_____

Has puberty begun? □Yes □No Has menstruation begun? (Girls) □Yes □No

Your child's current physical health is: □Good □Fair □Poor

Please list all drugs your child is taking:_____

_____

Please list all drugs your child is allergic to:_____

_____

- 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.
- I understand that the information 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.

_____

Signature Date

Doctor's comments: _____

_____

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