Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit **pleasant and educational.** Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a **beautiful smile that lasts a lifetime.**

Designer SMILES by Gary K Kevorkian DDS, MS

Orthodontics designed to last a lifetime

1 Tell Us About Your Child

Today's Date:_____

Child's Name: _____
Last First

❑ Male ❑ Female

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

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? _____

List brothers/sisters with age: _____

_____

General Dentist: _____

Last Visit Date: _____

Parents' Marital Status: ❑ Single ❑ Widowed ❑ Separated ❑ Married ❑ Divorced

3 Parent's/Guardian Information

Mother's Information: ❑ Step Mother ❑ Guardian

Name: _____
First Last

Wk#_____Ext _____Hm#_____

Cell #:_____ Date of Birth:_____/_____/_____

Employer: _____

Email:_____

Father's Information: ❑ Step Father ❑ Guardian

Name: _____
First Last

Wk#_____Ext _____Hm#_____

Cell #:_____ Date of Birth:_____/_____/_____

Employer: _____

Email:_____

4 Person Responsible for Account

Name:_____

Relation:_____

Billing Address _____

_____

Wk#_____Ext# _____Hm#_____

Cell: _____ Email _____

Employer:_____

DL#: _____SS# _____

5 Orthodontic Insurance

Orthodontic Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address_____

Insurance Co. Phone #_____

Group # (Plan, Local or Pollicy #) _____

Policy Owner's Name_____

Relationship to Patient_____

Policy Owner's Birthdate_____ SS# _____

Policy Owner's Employer:_____

continued on back

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

Y N	Anemic / Radiation Treatment	Y N	Heart Surgery / Pacemaker
Y N	Artificial Bones / Joints	Y N	Hemophilia / Abnormal Bleeding
Y N	Artificial Valves	Y N	Hepatitis
Y N	Asthma / Arthritis	Y N	High / Low Blood Pressure
Y N	Blood Transfusion	Y N	HIV+ / AIDS
Y N	Cancer / Chemotherapy	Y N	Hospitalized for any reason
Y N	Congenital Heart Defect	Y N	Kidney Problems
Y N	Diabetes / Tuberculosis (TB)	Y N	Mitral Valve Prolapse
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Drug Alcohol Abuse	Y N	Rheumatic / Scarlet Fever
Y N	Emphysema / Glaucoma	Y N	Severe / Frequent Headaches
Y N	Epilepsy / Seisures /	Y N	Shingles
Y N	Fever Blisters / Herpes	Y N	Sinus Problems
Y N	Heart Attack / Stroke	Y N	Ulcers / Colitis
Y N	Heart Murmur	Y N	Venereal Disease

Please list any serious medical condition(s) that your child has ever had:

_____

_____

_____

_____

_____

_____

_____

7 Is your child allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Tetracycline	Y N	Erythromycin	Y N	Any Metal / Plastic
Y N	Codeine	Y N	Latex	Y N	Other

Please list any other drugs that your child is allergic to:

_____

_____

8 Does 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

Please list any other habits you child may have:

_____

_____

_____

9 Release & Waiver

I understand that the information that I have given is correct to the best of my knowledge. I also understand it is my responsibility to inform the orthodontist and staff of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services my child may need. By signing this form, I give consent to use and disclose my child's health information to carry out treatment, payment activities and healthcare operations. I authorize release of any information regarding my child's orthodontic treatment to my dental insurance company.

Parent/Guardian Signature: _____ Date: _____

I authorize the office to use my child's picture for promotional purpose.

Parent/Guardian Signature: _____ 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 & ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

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

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____