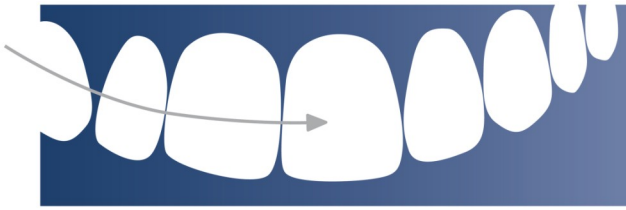

SURBECK ORTHODONTICS

WELCOME TO OUR OFFICE

So that we might become better acquainted, please complete **both** sides of this form.

CHILD PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____ ❒Female ❒ Male

First M.I. Last

Home Address: _____ City/State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Age: _____ Birth date: ____/____/____ School: _____

Email: _____ Patient Interest/Hobbies/Sports: _____

Who referred you and/or how did you find out about our office? _____

Do you know a patient currently in our practice? If so, who? _____

List all other family members who have received orthodontic treatment in our office: _____

Parent or Guardian's Marital Status: ❒Single ❒Married ❒Separated ❒Divorced ❒ Widowed

Patient resides with: ❒ Both Parents ❒ Mother ❒ Father Person(s) responsible for account _____

	Father	Mother	Step-parent/Guardian
Name:			
Address: (if different than above)			
Cell Phone:	(____) _____ - _____	(____) _____ - _____	(____) _____ - _____
Social Security Number:	_____ - _____ - _____	_____ - _____ - _____	_____ - _____ - _____
Employer/Occupation:			
Work Phone:	(____) _____ - _____	(____) _____ - _____	(____) _____ - _____

Sister(s) Name(s): _____ Brother(s) Name(s): _____

We will gladly assist you in submitting your insurance claims. Release of benefits and information: I authorize my insurance benefits to be paid directly to Dr. Burleigh Surbeck and that I am financially responsible for any balance due. I authorize Dr. Surbeck or the insurance company to release any information required for this claim. I recognize that the New Patient Child Exam fee is $30, which I will pay should my insurance not cover the exam.

Policy Holder's Name: _____ ID # _____ Birth date: _____/_____/_____

Insurance Company: _____ Group # _____ Phone # _____

Employer: _____

Policy Holder's Name: _____ ID # _____ Birth date: _____/_____/_____

Insurance Company: _____ Group # _____ Phone # _____

Employer: _____

Signature: _____ Date: _____

Please complete the backside of this form.

FOR OFFICE USE ONLY:

Benefit Amount $ _____ Benefit Used $ _____ Deductable:$ _____ Age Limit: _____

Method of Payment ❒ Monthly ❒ Quarterly ❒ Annual ❒ Other Continuation Form ❒ YES ❒ NO

Confirmed on: ____/____/____ By: _____

Patient's Dentist: _____ _____ Approximate date of last check-up _____ _____
(city) (mo) (yr)

Has your child had any previous orthodontic treatment? ❒NO ❒YES If yes, with whom? _____
If yes, satisfied? _____

Has your child consulted an orthodontist previously? ❒NO ❒YES If yes, with whom? _____

Patient's/Parents' primary concerns: _____

Has any other immediate family members received orthodontic treatment? ❒NO ❒YES If yes, with whom and satisfied? _____

Are there any concerns about having orthodontic treatment? ❒Discomfort ❒Appearance ❒Length of treatment ❒Other

DENTAL HISTORY

Does your child have a fear of dental treatment? ❒NO ❒YES Explain: _____

Has your child had an unpleasant experience in a dental office? ❒NO ❒YES Explain: _____

Is there any unfinished care to be completed by your child's dentist? ❒NO ❒YES Explain: _____

Has there been any injuries to the face, mouth, chin or teeth? ❒NO ❒YES Explain: _____

Has your child had any baby or permanent teeth removed? ❒NO ❒YES Explain: _____

Have you been informed of any missing or extra permanent teeth? ❒NO ❒YES Explain: _____

Is your child concerned about the appearance of his/her teeth? ❒NO ❒YES Explain: _____

Does your child have difficulty chewing or swallowing food? ❒NO ❒YES Explain: _____

Does your child have any speech problems or tongue thrust? ❒NO ❒YES If yes, what sounds?

Does your child grind or clench their teeth while sleeping or awake? ❒NO ❒YES ❒AWAKE ❒ASLEEP

Has your child ever sucked a thumb or finger? ❒NO ❒YES If yes, until what age?_____ Currently? _____

Does your child frequently breathe through their mouth? ❒NO ❒YES ❒AWAKE ❒ASLEEP

Does your child have any clicking, popping or soreness of the jaw joint? ❒NO ❒YES Explain: _____

TO DETERMINE YOUR CHILD'S GROWTH POTENTIAL:

Has your son or daughter reached puberty? ❒NO ❒YES Explain: _____

Girls– Has she started menstruation? ❒NO ❒YES Explain: _____

Boys– Has his voice changed? ❒NO ❒YES Explain: _____

Child's height _____ Do you feel growth has completed? ❒NO ❒YES Explain: _____

Father's Height_____ Mother's Height_____

Is your child adopted ❒NO ❒YES Explain: _____

MEDICAL HISTORY

Does your child have any allergies? ❒NO ❒YES Explain: _____
(ex: medications, foods, latex, bees)

Is your child currently taking any medication? ❒NO ❒YES Explain: _____

Has your child experienced any health problems? ❒NO ❒YES Explain: _____

Any major changes in your child's health recently? ❒NO ❒YES Explain: _____

Is your child currently under physician's care? ❒NO ❒YES Explain: _____

Have your child's tonsils or adenoids been removed? ❒NO ❒YES Explain: _____

Has your child ever received a blood transfusion? ❒NO ❒YES Explain: _____

Has your child been in a risk group for aids? ❒NO ❒YES Explain: _____

Please check *ONLY* if your child has had any of the following conditions:

❒ Heart Murmur
❒ Heart Surgery
❒ Artificial Valves/Stents
❒ Rheumatic fever
❒ Endocrine Disorder
❒ Prolonged Bleeding
❒ Anemia
❒ Blood Disease
❒ Development Disorder
❒ Hives/Rash
❒ Artificial Joints
❒ Hepatitis A (infectious)
❒ Hepatitis B
❒ Hepatitis C
❒ Diabetes
❒ Kidney Disease
❒ Liver Disease
❒ Tuberculosis
❒ Bronchitis
❒ Asthma
❒ Epilepsy
❒ Fainting
❒ Emotional problems
❒ Frequent Headaches
❒ Nervous/ Anxious
❒ Shortness of Breath
❒ Cancer
❒ Bone Disorder
❒ Growth Disorder
❒ Herpes (Fever Blisters)
❒ Tonsillitis
❒ HIV Positive (AIDS)

Is there any other condition that you think we should know about? _____

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.

Signature _____ Date ___/___/___