TASIOS ORTHODONTICS

Child Orthodontic Acquaintance Form

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ (mm/dd/yy) Age: _____ Sex: M F School/Grade: _____

Home Address: _____ City: _____ Postal Code: _____

Number of Children in the Family: _____ Name(s) & Age(s): _____

Mother's Name: _____ Phone: _____ Email: _____

Father's Name: _____ Phone: _____ Email: _____

Person responsible for the account: _____

Reason for orthodontic consultation: _____

Who may we thank for referring you? _____

INSURANCE INFORMATION. Does the patient have orthodontic coverage? Yes No

Primary Policy Holder's Name: _____ Date of Birth: _____ (mm/dd/yy) Employer: _____

Insurance Provider: _____ Policy#: _____ Certificate/ID#: _____

Secondary Policy Holder's Name: _____ Date of Birth: _____ (mm/dd/yy) Employer: _____

Insurance Provider: _____ Policy#: _____ Certificate/ID#: _____

MEDICAL HISTORY. Has your child been treated for the following (please circle)

Asthma	Thyroid	Osteoporosis	Artificial Joints	Arthritis
HIV/Aids	Sleep Apnea	Tuberculosis	Epilepsy/Seizures	Diabetes
Kidney Disorder	Blood Pressure	Heart Condition	Artificial Heart Valve	Liver Disease
Other (please specify) _____		Hepatitis A/B/C	Prolonged Bleeding	Heart Murmer

Patient's Physician Name and Phone #: _____

Does your child require antibiotic premedication for dental procedures? _____

Does your child currently take any prescription medications? _____

Does your child have any allergies? Yes No If yes, please specify: _____

DENTAL HISTORY.

Patient's Dentist Name and Phone #: _____ Date of last dental check-up: _____ (mm/dd/yy)

Is there a history of any injuries to your child's mouth/teeth/face? Yes No If yes, please specify: _____

Has your child ever sucked his/her thumb? Yes No

Does your child breathe through his/her mouth? Yes No

Does your child have any speech problems? Yes No

Have you been informed of any missing permanent teeth? Yes No

Has your child ever had an orthodontic consultation before? Yes No

Has your child ever had orthodontic treatment in the past? Yes No

Please list any sports, hobbies or musical instruments: _____

I hereby give Dr. Bruce Tasios and/or members of his staff permission to release information concerning my dental and/or orthodontic health to my family physician, dentist or any other dental specialist as deemed necessary to optimize my oral health. Such information includes radio-graphs and other diagnostic records which pertain to the condition, diagnosis, or proposed treatment.

We will provide the highest level of confidentiality with respect to the collection and disclosure of all your personal information that is provided to us.

I, the undersigned, certify that I have read and understood the above medical and dental information and have answered the questions in an accurate manner. If there are any changes to my medical history, I recognize that it is my responsibility to inform the office. I also give permission for Dr. Bruce Tasios to complete the clinical examination.

_____ _____

Signature of Parent/Guardian Date