

# JOSEPH P. GIORDANO, D.M.D. - JOHN B. C. LEM, D.M.D.

SPECIALISTS IN ORTHODONTICS FOR CHILDREN & ADULTS

We would like to welcome you and your child to our practice. Please take a few minutes to fill out this form and return it to our office prior to your first visit. We look forward to working with your child.

## TELL US ABOUT YOUR CHILD

Date: \_\_\_\_\_ Child's name: \_\_\_\_\_

SS#: \_\_\_\_\_ Nickname: \_\_\_\_\_  M  F

Child's birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's age: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_

Hobbies/sports: \_\_\_\_\_

Child's home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Child's home #: \_\_\_\_\_ Child's cell #: \_\_\_\_\_

Child's e-mail: \_\_\_\_\_

List brother/sisters w/age: \_\_\_\_\_

\_\_\_\_\_

General dentist: \_\_\_\_\_

Last visit date: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Who will be accompanying your child on their first visit?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

Parents marital status:  Single  Married  Widowed  Divorced  Separated

## MOTHER'S INFORMATION

Mother  Step Mother  Guardian

Name: \_\_\_\_\_

Work #: \_\_\_\_\_ Ext.: \_\_\_\_\_ Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_ SS#: \_\_\_\_\_

E-mail: \_\_\_\_\_

## FATHER'S INFORMATION

Father  Step Father  Guardian

Name: \_\_\_\_\_

Work #: \_\_\_\_\_ Ext.: \_\_\_\_\_ Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_ SS#: \_\_\_\_\_

E-mail: \_\_\_\_\_

## APPOINTMENT CONTACT INFORMATION

Name: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

E-mail  Home #  Work #  Cell #

## PERSON RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work #: \_\_\_\_\_ Ext.: \_\_\_\_\_ Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ # yrs. employed \_\_\_\_\_

E-mail: \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Orthodontic Coverage:  Yes  No

Insurance Co. name: \_\_\_\_\_

Insurance Co. address: \_\_\_\_\_

Insurance Co. phone #: \_\_\_\_\_

Group # (plan, local or policy #): \_\_\_\_\_

Insured's name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_

Insured's employer: \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

Orthodontic Coverage:  Yes  No

Insurance Co. name: \_\_\_\_\_

Insurance Co. address: \_\_\_\_\_

Insurance Co. phone #: \_\_\_\_\_

Group # (plan, local or policy #): \_\_\_\_\_

Insured's name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_

Insured's employer: \_\_\_\_\_

FORM CONTINUES ON BACK



Members American Association of Orthodontists

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## DENTAL HISTORY

Why are you interested in orthodontic treatment for your child? \_\_\_\_\_

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

Does your child have any habits/problems affecting the mouth or teeth?  Thumb/finger sucking  Nail biting  Clenching/grinding teeth

Lip sucking/biting  Mouth breather  Tongue thrust Other \_\_\_\_\_

List any musical instruments played \_\_\_\_\_

Has anyone in your family received orthodontic treatment?  Yes  No

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Yes  No

How often does your child brush? \_\_\_\_\_ Floss? \_\_\_\_\_

Other information about your child's dental health or previous treatment \_\_\_\_\_

Has your child's physician recommended pre-medication with antibiotics before dental treatment?  Yes  No

## MEDICAL HISTORY

Child's Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Has your child had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Is your child currently under physician care?  Yes  No If yes, describe \_\_\_\_\_

Has your child ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

Have your child's adenoids or tonsils been removed?  Yes  No

Check yes or no if your child had any of the following?

<input type="checkbox"/> Y <input type="checkbox"/> N	AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaw pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of breath
<input type="checkbox"/> Y <input type="checkbox"/> N	Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney disease or malfunction	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus problems
<input type="checkbox"/> Y <input type="checkbox"/> N	Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin rash
<input type="checkbox"/> Y <input type="checkbox"/> N	Atopic (allergy prone)	<input type="checkbox"/> Y <input type="checkbox"/> N	Food allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Material allergies (latex, wool, metal, chemicals)	<input type="checkbox"/> Y <input type="checkbox"/> N	Spina Bifida
<input type="checkbox"/> Y <input type="checkbox"/> N	Blood disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Respiratory disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid disease or malfunction
<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic/Scarlet fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Tonsillitis
<input type="checkbox"/> Y <input type="checkbox"/> N	Convulsions/Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Hearing impairment	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N	Cough, persistent	<input type="checkbox"/> Y <input type="checkbox"/> N	Hemophilia/Abnormal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____
<input type="checkbox"/> Y <input type="checkbox"/> N	Cough up blood						

Please describe any Yes answers and discuss any additional medial conditions that your child has had: \_\_\_\_\_

Please list any medications your child is currently taking: \_\_\_\_\_

Please list all drugs that your child is allergic to: \_\_\_\_\_

## AUTHORIZATION

I understand that the information that I have given on this questionnaire is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence and used by the orthodontist to help determine appropriate and healthful orthodontic treatment. It is my responsibility to inform this office of any change in my child's medical status.

I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_