

WELCOME TO CRANE & SEAGER ORTHODONTICS

Making A Difference, One Smile At A Time

Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime. Please fill out this form completely so we can best care for you.

1 TELL US ABOUT YOUR CHILD

Today's Date: _____
 Email Address: _____
 May We Email You With Special Offers, Exclusive Events & Contests: Yes No
Child's Name: _____
 Nickname: _____ Male Female
CHILD PREFERS TO BE CALLED
 Birthdate: ____/____/____ Age: ____
 School: _____ Grade: _____
 Hobbies: _____
 Sports Teams My Child Plays On: _____
 Organizations My Child Is Involved With: _____
Child's Home Address: _____
APT/CONDO #

CITY STATE ZIP
 Hm #: (____) _____ Cell/Other #: (____) _____

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 to us? _____
 List brothers/sisters with age: _____

 General Dentist: _____
 Child's Last Visit Date: _____
 Parent's Marital Status: Single Partnered Divorced
 Married Separated Widowed

3 PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
 Billing Address: _____
APT/CONDO #

CITY STATE ZIP
 Hm #: (____) _____ DL #: _____
 Cell #: (____) _____ SS #: _____
 Employer: _____ Wk #: (____) _____ Ext. _____

4 PARENT/GUARDIAN INFORMATION

Mother's Information Step Mother Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

May We Email You With Special Offers, Exclusive Events & Contests: Yes No

Cell #: (____) _____ Hm #: (____) _____

Employer: _____ Wk #: (____) _____

Father's Information Step Father Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

May We Email You With Special Offers, Exclusive Events & Contests: Yes No

Cell #: (____) _____ Hm #: (____) _____

Employer: _____ Wk #: (____) _____

5 ORTHODONTIC INSURANCE

PRIMARY ORTHODONTIC INSURANCE INFORMATION

Orthodontic Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Member ID # or Policy #: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ **Insured's ID#:** _____

Insured's Employer: _____

SECONDARY ORTHODONTIC INSURANCE INFORMATION

Orthodontic Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Member ID # or Policy #: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ **Insured's ID#:** _____

Insured's Employer: _____

CONTINUED ON BACK

4

CHILD'S MEDICAL HISTORY

Your child's physical health is: Good Fair Poor
Is your child currently under the care of a physician? Yes No
Please explain: _____

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

Has puberty begun? Yes No

Has menstruation begun? (Girls) Yes No

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

- | | |
|------------------------------------|---------------------------------|
| Y N Abnormal Bleeding | Y N Hearing Impairment |
| Y N ADD/ADHD | Y N Heart Murmur |
| Y N Any Operations | Y N Hemophilia |
| Y N Artificial Bones/Joints/Valves | Y N Hepatitis |
| Y N Asthma | Y N HIV+/AIDS |
| Y N Blood Transfusion | Y N Hospitalized for Any Reason |
| Y N Cancer | Y N Kidney/Liver Problems |
| Y N Congenital Heart Defect | Y N Lupus |
| Y N Diabetes | Y N Rheumatic/Scarlet Fever |
| Y N Epilepsy/Seizures/Fainting | Y N Sickle Cell Disease/Traits |
| Y N Handicaps/Disabilities | Y N Tuberculosis (TB) |

Please discuss any medical problems your child has had:

Please list all drugs that your child is currently taking:

Are you allergic to any of the following:

- | | | |
|-------------------------|------------------|------------------|
| Y N Dental Anesthetics | Y N Aspirin | Y N Penicillin |
| Y N Any Metals/Plastics | Y N Erythromycin | Y N Tetracycline |
| Y N Codeine | Y N Latex | Y N Other |

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

5

CHILD'S DENTAL HISTORY

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

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

Have there been any injuries to the face, mouth, teeth or chin? Yes No

List any musical instruments played: Yes No

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does your child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Does/did your child have any of the following habits?

- | | |
|------------------------------|--------------------------|
| Y N Clenching/Grinding Teeth | Y N Nursing Bottle |
| 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 |



I understand that the information that 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature of Parent or Guardian

Date



Thank You for filling out this form completely.

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 and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature of Parent or Guardian

Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

Signature of Parent or Guardian

Date

Our Office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the 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: _____

