Columbus Orthodontic Center

CENTER FOR COSMETIC ORTHODONTIC TREATMENT

Amin Mason, DDS, MSD
New Patient Information (Child)

Child's Name: _____

Today's Date: _____/_____/_____

Child's Information

Date of Birth: _____/____/_____Age:_____
Sex: ☐ Male ☐ Female
Address: _____
City: _____ State: _____ Zip: _____

Are you the legal guardian of the child? ☐ Yes ☐ No
If you are not the biological parent of the child and have guardianship, please provide a copy of legal documents.

Responsible Party's Information

Mother's / Female responsible party's Information

Name: _____Relation to child: _____
Date of Birth: _____/_____/_____
Address: _____
City: _____ State: _____Zip: _____
E-mail:_____
Home Phone: _____
Cell Phone: _____
Employer: _____
Occupation: _____

Father's/ Male responsible party's Information

Name: _____Relation to child: _____
Date of Birth: _____/_____/_____
Address: _____
City: _____ State: _____ Zip: _____
E-mail:_____
Home phone:_____
Cell Phone: _____
Employer: _____
Occupation: _____

Other Information

How did you hear about us? (Please circle your answer)
Dentist referral Insurance referral Internet search
Mailer Drive-by
Friends/Family (specify who):_____
Other: _____

What is the primary reason for your visit today?
_____

Has the child ever had orthodontic treatment? ☐Yes ☐No

Has the child had a consultation previously? ☐Yes ☐No

Is the child transferring from another practice? ☐Yes ☐No
Previous Orthodontist's name: _____

Were you satisfied with the previous orthodontic treatment?
☐ Yes ☐ No ☐ NA

Does the child have any hobbies or participate in any sports?
_____

What type/types of treatment options are you interested in?
☐Traditional Braces **☐Invisalign clear trays**
☐Clear braces **☐ Lingual/ Hidden braces**

Insurance Information

Is the patient covered under DENTAL insurance? ☐ Yes ☐ NO

Subscriber's Name_____
Subscriber's relationship to patient: ☐ Mother ☐ Father
☐Other (please explain): _____
Subscriber's Date of Birth: _____/_____/_____
Subscriber's member ID #: Some insurances require SS#:
_____
Group, Plan or Policy #: _____
Name of subscriber's employer: _____
Insurance company's name: _____
Insurance company's Phone #: _____
Insurance address: _____
City: _____State _____Zip_____

ALL insurance information must be completed to verify benefits. Please provide us with a copy of your dental insurance card.

Secondary Insurance must be filed by the patient.

Patient's Dental History

Dentist's Name: _____
Address: _____
Phone: _____
Approximate date of last visit: Month_____/Year_____
Were there any cavities or dental problems present?
□ Yes □ No If yes, please explain: _____
_____
Has the child ever experienced dental or facial trauma? (Examples include: Dental injuries, car accident, jaw or facial injuries related to sports or falling). □Yes □No
If yes, Please Explain: _____

Does the child have or have had any of the following habits?
___Thumb sucking ___ Mouth breathing
___Tongue thrusting ___Nail biting/chewing
___Smoking ___ Snoring

Does the child have or ever had a history of the following?
___Grinding/clenching ___Jaw popping
___Jaw/Joint clicking ___Ringing in ears
___Jaw/Joint soreness ___Excessive headaches

Patient's Medical History

Is the child under the care of a physician □ Yes □ No

Name of Physician: _____
Address: _____
Phone #: _____

Does the child have a hyperactive gag reflex? □ Yes □ No

Has the child ever been advised to take antibiotics before dental treatment? □ Yes □ No

For Female Patients only:

Is the child pregnant or possibly pregnant? □ Yes □ No

Has the child started menstrual cycle? □ Yes □ No

Does the child have or have had a history of the following:
Please circle "Y" for yes or "N" for no.

Heart murmur	Y	N	Hepatitis	Y	N
Blood disease	Y	N	Herpes	Y	N
Anemia	Y	N	Epilepsy/Seizures	Y	N
Heart disease	Y	N	Tuberculosis	Y	N
HIV/AIDS	Y	N	Adenoids Removal	Y	N
Diabetes	Y	N	Endocrine problem	Y	N
Tonsillitis	Y	N	Prolonged bleeding	Y	N
Jaundice	Y	N	Bone disorder	Y	N
Asthma	**Y**	**N**	Rheumatic fever	Y	N
Mouth breathing	Y	N	Sinus Infections	Y	N
Chemotherapy	Y	N	Allergic reaction	Y	N
Surgeries	Y	N	Radiation	Y	N
Cancer	Y	N	Autism/Asperger's	Y	N
Mental disorders	Y	N	Anxiety	Y	N
ADD/ADHD	Y	N	Learning Disabilities	Y	N

Please Explain: _____
_____

Please list ALL medical conditions not list above:

_____
_____

Is the child currently taking **any** medications? □Yes □No
If Yes, please list:

_____
_____
_____

Is the child allergic to **any** medications, food or latex?
□Yes □No Please list all:

_____
_____

YOUR NAME:

_____

YOUR RELATION TO CHILD: _____

SIGNATURE:

_____

Doctor's Comments:

Doctor's Signature: _____ **Date:** _____/_____/_____