Vanderwall ORTHODONTICS

Clay VanderWall DDS PA

Children's Personal Information Form

1. Tell us about your child:

Today's date: _____ DOB:_____

Child's Name: Age: _____

_____

Last First Middle

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Home Phone #: _____

SS #: _____

Child's Home Address: _____

_____ Apt. #: _____

City: _____ State: _____ Zip: _____

Dental Information:

Previous/Present Dentist: _____

Address: _____

Phone #: _____Last visit: _____

2. Who is with the child today?

Name: _____

Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Parent's marital status: ☐ Single ☐ Married ☐ Divorced

List other family members seen by us: _____

_____

Who may we thank for referring you to us?

_____

3. Parent's Information:

Mother's Name: _____

Wk. Ph. #: _____ Hm. Ph. #: _____

Cell Phone #: _____

Employer: _____

Dr. Lic. #: _____ State _____

SS #: _____

Father's Name: _____

Wk. Ph. #: _____ Hm. Ph. #: _____

Cell Phone #: _____

Employer: _____

Dr. Lic. #: _____ State _____

SS #: _____

4. Responsible Party Information:

Name: _____

Billing Address: _____

_____ Apt. #: _____

City: _____ State: _____ Zip: _____

Wk. Ph. #: _____ Hm. Ph. #: _____

Cell Phone #: _____

Employer: _____

Dr. Lic. #: _____ State _____

SS #: _____ Email: _____

Who is responsible for making appointments?

Name: _____

Wk. Ph. #: _____ Hm. Ph. #: _____

5. Primary Dental Insurance:

Ins. Co. Name: _____

Ins. Co. Address: _____

_____

Ins. Co. Phone Number: _____

Group/Policy Number: _____

Insured's Name: _____

Relationship to patient: _____

Insured's date of birth: _____

Insured's employer: _____

SS # of Insured: _____

Orthodontic coverage? ☐ Yes ☐ No

Secondary Dental Insurance:

Ins. Co. Name: _____

Ins. Co. Address: _____

_____

Ins. Co. Phone Number: _____

Group/Policy Number: _____

Insured's Name: _____

Relationship to patient: _____

Insured's date of birth: _____

Insured's employer: _____

SS # of Insured: _____

Orthodontic coverage? ☐ Yes ☐ No

6. Why did you bring the child to us today?

Has the child ever had a serious/difficult problem associated with dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush teeth daily? ☐ Yes ☐ No

Does the child floss daily? ☐ Yes ☐ No

Is the child currently under the care of a physician? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Last visit: _____

Please describe the child's health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs the child is currently taking:

_____

_____

_____

Please list all drugs the child is allergic to:

_____

_____

_____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

7. Has the child ever had any of the following medical problems or events? (Please circle Yes or No)

Y N Heart Murmur	Y N Congenital Heart Defect
Y N Cancer	Y N Convulsions/Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheumatic Fever	Y N Hearing Impairment
Y N HIV+/AIDS	Y N Surgical Operations
Y N Hemophilia	Y N Hospital Stays
Y N Asthma	Y N Kidney/Liver Problems
Y N Hepatitis	Y N Handicaps/Disabilities
Y N Tuberculosis	Y N Allergies to Any Drugs
Y N Prosthesis	Y N History of Scarlet Fever

Please discuss any serious medical problems that the child has had: _____

_____

_____

(Please circle Yes or No)

Y N Thumb Sucking / Finger Sucking

Y N Allergic to LATEX

Have they ever taken medications (such as bisphosphonates) that affect the bone or to prevent bone disease. (e .g. - Fosamax, Zometa, Actonel, Aredia) Y N

8. I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent/Guardian Date

The parent/guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Initials: _____ Date: _____

Doctor's comments: _____

_____

_____

_____

Medical history updates:

1. Date: _____ Signature: _____

Comments: _____

2. Date: _____ Signature: _____

Comments: _____

3. Date: _____ Signature: _____

Comments: _____

4. Date: _____ Signature: _____

Comments: _____

5. Date: _____ Signature: _____

Comments: _____

6. Date: _____ Signature: _____

Comments: _____

7. Date: _____ Signature: _____

Comments: _____