Lorin A. Kaplan DDS, MSD
Orthodontic Specialist

Member American Association of Orthodontists

Child Information Form

We would like to welcome you and your child to our office. Our goal is to provide your family with the best possible care and service and to make every child's visit pleasant and educational. To help us get to know you & your family better, please provide the patient information below. If you have questions or need assistance, we'll be happy to help.

Tell Us About Your Child

Child's Full Name_____ Nickname_____
First Middle Last

Address_____
Street City State Zip

Birthdate_____ Age_____ Male_____ Female_____ School_____ Grade_____

Child's mobile #_____ Child's home #_____ Child's E-mail_____

❑ Yes ❑ No Can we text or e-mail appointment and treatment reminders to your child?

❑ Yes ❑ No Can they participate in our **practice reward program**?

Career Goals / Hobbies / Activities:_____

List any Brothers / Sisters _____ Ages:_____

Who May We Thank For Referring You?_____ Friends who also see Dr. Kaplan_____

Responsible Party Information

Marital Status of Parents: ❑ Single ❑ Domestic Partner ❑ Married ❑ Divorced

With whom does the patient live? ❑ Parents ❑ Mother ❑ Father ❑ Guardian_____

Who should receive treatment progress updates? ❑ Mother ❑ Father ❑ Guardian_____

Preferred contact method for appt. reminders: ❑ Home phone ❑Work phone ❑ Mobile ❑ e-mail

Step-Mother (if applicable)_____ Step-Father (if applicable)_____

Responsible Billing Party ❑ Mother ❑ Father ❑ Guardian_____

Parent / Guardian_____
Name Mobile # E-mail address

_____
Occupation Employer Work# SSN

Parent / Guardian_____
Name Mobile # E-mail address

_____
Occupation Employer Work# SSN

Emergency Information

Emergency Contact_____
Neighbor, friend or Relative not living with you. Relationship Contact phone#

t. 415.479.4543 ▪ f. 415.479.4545 ▪ smiles@kaplanorthodontics.com
920 Northgate Drive, Suite 8 ▪ San Rafael, CA 94903 ▪ www.kaplanorthodontics.com

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Insurance Information

❑yes ❑no **Orthodontic Coverage?** If yes please complete below:

Subscriber's Name_____Subscriber's DOB_____Subscribers ID# (SSN)_____

Subscriber's Employer | Primary Insurance Company | Group# | Insurance Co. Phone#

Insurance Co Address | City | State | Zip

❑yes ❑no **Do you have dual coverage?** If yes please complete below:

Subscriber's Name_____Subscriber's DOB_____Subscibers ID# (SSN)_____

Subscriber's Employer | Primary Insurance Company | Group# | Insurance Co. Phone#

Insurance Co Address | City | State | Zip

Medical History

Patient's Physician_____

Date Of Last Visit

❑yes ❑no Is your child under the care of a physician? ❑yes ❑no Is your child in good health?

❑yes ❑no **Drugs or medications** currently taken ?_____

❑yes ❑no Has your physician advised **prophylactic antibiotics** for dental procedures?

❑yes ❑no Has your child been hospitalized or had any surgery?

If Yes, please explain_____

❑yes ❑no Child ever taken oral or iv **bisphosphonates** (ie. Fosamex, Boniva, Actonal, Reclast, etc.) for bone disorders or cancer?

❑yes ❑no Does Your Child Need Help With Instructions?

Are there any special circumstances for your child at home or school

If yes, how & why_____

Does your child have any allergies or reactions to any of the following:

❑yes ❑no ❑unsure	Aspirin?	❑yes ❑no ❑unsure	Ibuprofen (Motrin, Advil)?
❑yes ❑no ❑unsure	Penicillin or antibiotics?	❑yes ❑no ❑unsure	Sulfa drugs?
❑yes ❑no ❑unsure	Latex? (balloons, gloves)	❑yes ❑no ❑unsure	Acrylic?
❑yes ❑no ❑unsure	Metals?	❑yes ❑no ❑unsure	Foods, flavorings or colorings?

Please answer the following about Your Child:

❑yes ❑no ❑unsure	AIDS or HIV positive?	❑yes ❑no ❑unsure	Headaches, Migranes?
❑yes ❑no ❑unsure	Anemia?	❑yes ❑no ❑unsure	Hepatitis?
❑yes ❑no ❑unsure	Arthritis?	❑yes ❑no ❑unsure	Herpes?
❑yes ❑no ❑unsure	Asthma?	❑yes ❑no ❑unsure	Heart trouble?

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❑yes ❑no ❑unsure	Birth Defects/Hereditary problems?	❑yes ❑no ❑unsure	Heart murmur?
❑yes ❑no ❑unsure	Behavioral/Emotional/ Disorders	❑yes ❑no ❑unsure	High blood pressure?
❑yes ❑no ❑unsure	Bleeding Disorders?	❑yes ❑no ❑unsure	Immune Disorders?
❑yes ❑no ❑unsure	Bone Disorders?	❑yes ❑no ❑unsure	Kidney Disorders?
❑yes ❑no ❑unsure	Bone Fractures?	❑yes ❑no ❑unsure	Liver Disorders
❑yes ❑no ❑unsure	Chew or smoke tobacco?	❑yes ❑no ❑unsure	Muscle Disorders?
❑yes ❑no ❑unsure	Cancer or Tumors?	❑yes ❑no ❑unsure	Mental Illness, depression?
❑yes ❑no ❑unsure	Diabetes?	❑yes ❑no ❑unsure	Nervous Disorders?
❑yes ❑no ❑unsure	Dizziness?	❑yes ❑no ❑unsure	Respiratory problems, emphysema?
❑yes ❑no ❑unsure	Eating Disorders?	❑yes ❑no ❑unsure	Rheumatic Fever?
❑yes ❑no ❑unsure	Endocrine Disorders?	❑yes ❑no ❑unsure	Speech Therpy
❑yes ❑no ❑unsure	Epilepsy?	❑yes ❑no ❑unsure	Tonsil or Adenoid conditions?
❑yes ❑no ❑unsure	Fainting Spells?	❑yes ❑no ❑unsure	Tuberculosis?
❑yes ❑no ❑unsure	Gastrointestinal Disorders?	❑yes ❑no ❑unsure	Substance abuse past or present

❑yes ❑no ❑unsure Does your child have any disease, condition or Illness Not Mentioned Above:

If so, please explain_____

Genetics & Growth

❑yes ❑no Child adopted?

❑yes ❑no Have any family members had unusual dental problems or jaw size imbalances?

If so, please explain_____

Height of Parents? Mom_____Dad_____

Females ❑yes ❑no ❑unsure Has your daughter started her monthly periods yet?

Males ❑yes ❑no ❑unsure Voice Change or growth spurt

TMJ History

❑yes ❑no ❑unsure Has your child had a TMJ screening or been treated for "TMJ" or "TMD"?

❑yes ❑no ❑unsure Do they experience muscle soreness of their face or pain in their jaw joint?

❑yes ❑no ❑unsure Do they notice clicking or popping in their jaw joint?

❑yes ❑no ❑unsure Do they have difficulty chewing or opening their mouth?

❑yes ❑no ❑unsure Do they grind or clench their teeth?

❑yes ❑no ❑unsure Does their bite feel uncomfortable?

Dental History

Child's Dentist_____

date of last visit date of last dental x-rays

❑yes ❑no Is your child currently in any dental pain?

❑yes ❑no ❑unsure Is all dental work completed at this time?

❑yes ❑no ❑unsure Been under the care of a dental specialist? Specialist:_____

If so, please explain_____

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Has your child ever experienced any of the following?

❑yes ❑no ❑unsure Does your child brush his / her teeth daily?

❑yes ❑no ❑unsure Help with brushing or flossing?

❑yes ❑no ❑unsure Teeth sensitive to hot, cold or pressure?

❑yes ❑no ❑unsure Gums bleed when brushed or flossed?

❑yes ❑no ❑unsure Chipped or injured baby or permanent teeth?

❑yes ❑no ❑unsure Trauma to the neck, head, or jaw area?

❑yes ❑no ❑unsure History of speech problems or been under care of speech therapist?

❑yes ❑no ❑unsure Snoring, mouth or difficulty in breathing?

❑yes ❑no ❑unsure Abnormal swallowing habit (tongue thrusting)?

❑yes ❑no ❑unsure Thumb, finger or lip sucking habit? Until what age?_____

❑yes ❑no ❑unsure Extra or missing teeth from birth?

❑yes ❑no ❑unsure Any relative with similar tooth or jaw relationships, ie. Jaw size imbalances?

❑yes ❑no ❑unsure Are there any negative dental experiences or dental conditions not mentioned above that you feel we should be aware of?

If so, please explain_____

Orthodontic History

What is your primary concern about your child's bite, teeth or smile?

_____

❑yes ❑no ❑unsure Is your child self-conscious about their teeth ?

❑yes ❑no ❑unsure Members Of Your Family Had Orthodontic Care Including Yourself?

❑yes ❑no ❑unsure Have Your Child Ever Seen Or Referred to An Orthodontist? Who?_____When?_____

❑yes ❑no ❑unsure Would your child object to wearing orthodontic appliances (braces / aligners) if indicated?

What concerns do you have about having your child's teeth straightened?

Please check which applies: ❑Appearance ❑Cost ❑Pain ❑How Long ❑Success

Other concerns?_____

Benefits of Orthodontics: Aesthetics, Health & Function

Orthodontics is a service that provides an improvement in the appearance, function (bite), and general dental health. Teeth change throughout our lifetime and there can be some movement after treatment. Wearing of retainers throughout life will help minimize dental movement.

I understand that the information that I have given is correct to the best of my knowledge, that it will be in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's medical status. I authorize the dental staff to perform any necessary services needed during the diagnosis & tx of my child. 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 directly to this office.

_____

Signature of parent or guardian | Relationship | Date | Doctor's Initials | Date

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

Thanks so much for telling us about your child. We look forward to meeting you & your child soon!

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