

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

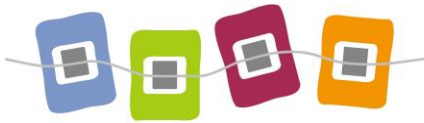
Parent / Guardian _____
Name Mobile # E-mail address

Occupation Employer Work# SSN

Emergency Information

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





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 _____ Subscribers 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 _____

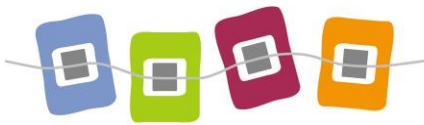
Does your child have any allergies or reactions to any of the following:

<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Aspirin?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Ibuprofen (Motrin, Advil)?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Penicillin or antibiotics?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Sulfa drugs?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Latex? (balloons, gloves)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Acrylic?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Metals?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Foods, flavorings or colorings?

Please answer the following about Your Child:

<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	AIDS or HIV positive?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Headaches, Migranes?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Anemia?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Hepatitis?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Arthritis?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Herpes?
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Asthma?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure	Heart trouble?





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|--|---|--|----------------------------------|
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Birth Defects/Hereditary problems? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Heart murmur? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Behavioral/Emotional/ Disorders | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | High blood pressure? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Bleeding Disorders? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Immune Disorders? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Bone Disorders? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Kidney Disorders? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Bone Fractures? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Liver Disorders |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Chew or smoke tobacco? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Muscle Disorders? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Cancer or Tumors? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Mental illness, depression? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Diabetes? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Nervous Disorders? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Dizziness? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Respiratory problems, emphysema? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Eating Disorders? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Rheumatic Fever? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Endocrine Disorders? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Speech Therapy |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Epilepsy? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Tonsil or Adenoid conditions? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Fainting Spells? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Tuberculosis? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Gastrointestinal Disorders? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Substance abuse past or present |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Does your child have any disease, condition or illness Not Mentioned Above: | | |

If so, please explain _____

Genetics & Growth

- yes no unsure Child adopted?
- yes no unsure 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?

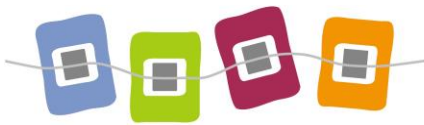
Dental History

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 _____





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
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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.

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

