Welcome to Haack Orthodontic Clinic.

Thank you for providing this important information and filling out this form in advance.

Today's Date:___/___/___

ABOUT YOUR CHILD

Child's Name:_____ Nickname:_____

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

_____

Age:_____ Date of Birth:_____/_____/_____ {Male {Female

Child's Home Address: _____

_____

Child's Home Phone Number:(_____)_____-_____

School:_____ Grade:_____

Hobbies/Sports:_____

Musical Instruments played:_____

Brothers and Sisters (and ages):_____

Whom may we thank for referring you to our office?_____

Child's General Dentist:_____

Approximate Date of Last Visit to General Dentist:_____/_____/_____

PARENT'S INFORMATION

Who is accompanying your child today?_____

Relationship to child:_____

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

Child's mother's name:_____

{Biological Mother {Step-Mother {Adoptive Mother

Home phone #: (_____)_____-_____ E-mail address:_____

Work phone #: (_____)_____-_____ Employer:_____

Child's father's name:_____

{Biological Father {Step-Father {Adoptive Father

Home phone #: (_____)_____-_____ E-mail address:_____

Work phone #: (_____)_____-_____ Employer:_____

Above mother/father marital status: {Married {Divorced {Separated {Single {Widowed

INSURANCE INFORMATION

Primary Insurance:

Dental Coverage? {Yes {No {Not Sure Orthodontic Coverage? {Yes {No {Not Sure

Insurance Company Name:_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's Birthdate:_____/_____/_____ Soc. Sec. #:_____

Policy Owner's Employer:_____

Secondary Insurance:

Dental Coverage? {Yes {No {Not Sure Orthodontic Coverage? {Yes {No {Not Sure

Insurance Company Name:_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's Birthdate:_____/_____/_____ Soc. Sec. #:_____

Policy Owner's Employer:_____

CHILD'S HEALTH HISTORY AND STATUS

Have there been any injuries to the face, mouth, teeth, or chin? ..…… {Yes {No
Do you know if your child has any missing or extra teeth? …… {Yes {No
Has your child ever had any pain/tenderness in the jaw joint (TMJ) area? .. {Yes {No
Does your child clench or grind his/her teeth? …….. {Yes {No
Is your child a mouth breather? …… {Yes {No
Has your child had a thumb or finger sucking habit? ……... {Yes {No
Please briefly explain any dental concerns above that were checked "yes":_____

_____

_____

Please list all drugs that your child is currently taking:_____

_____

Please list all drugs and other things your child is allergic to:_____

_____

Child's Physician:_____
Approximate date of last visit to physician:_____/_____/_____
Is your child currently under the care of a physician for a specific condition or problem? {Yes {No

Please circle any of the following medical concerns that your child has ever had:

Abnormal Bleeding	Heart Murmur
ADD / ADHD	Hemophilia
Allergic to any Drugs	Hepatitis
Allergic to Latex, Metals, or Plastic	HIV+ or AIDS
Artificial Bones, Joints, or Valves	Kidney or Liver Problems
Asthma	Lupus
Cancer	Recent Hospital Stays
Congenital Heart Defect	Recent Operations
Convulsions or Epilepsy	Rheumatic or Scarlet Fever
Diabetes	Sickle Cell Disease or Traits
Handicaps or Disabilities	Tuberculosis (TB)
Hearing Impairment	My child has had none of these concerns

Please briefly explain any positive medical concerns above and any others not listed above:_____

_____

_____

I UNDERSTAND THAT THE INFORMATION 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.

_____ _____
Signature of parent or guardian Date

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 this office, use the services of one or more credit reporting services.

Doctor's Comments and Review:_____

_____

_____