Orthodontic Solutions
for Children & Adults

Welcome to our office!

In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

Patient Information

○ Male ○ Female

Patient's Name _____ Age_____ Date of Birth (DOB)_____

Patient's Home Phone_____ Have we treated a family member? ○ Yes ○ No

Patient's Home Address_____ City/Zip_____

Patient's General Dentist (Name/City)_____

Whom may we thank for referring you?_____

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

Has your child visited an orthodontist before? ○ Yes ○ No If Yes, for what reason? _____

Who makes healthcare decisions for the patient? _____

Do you have legal custody? ○ Yes ○ No Who is financially responsible for the patient's care?_____

Is there anything you would like to discuss with the doctor in private? ○ Yes ○ No

Family Information..

Parents marital status: ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ Domestic Partner

○ Father ○ Step Father ○ Guardian Name _____

Home Phone_____ Cell Phone_____ Work Phone_____

E-mail Address_____

Employer (Name/City)_____DOB_____

Has he ever had Orthodontic treatment before? ○ Yes ○ No Does he want information about adult treatment? ○ Yes ○ No

○ Mother ○ Step Mother ○ Guardian Name _____

Home Phone _____Cell Phone_____ Work Phone_____

E-mail Address_____

Employer (Name/City)_____DOB_____

Has she ever had Orthodontic treatment before? ○ Yes ○ No Does she want information about adult treatment? ○ Yes ○ No

Siblings: Name/ DOB	Has the child had prior orthodontic treatment?	Would you like the child evaluated for orthodontic treatment?
_____	○ Yes ○ No	○ Yes ○ No

_____ ○ Yes ○ No ○ Yes ○ No

Dental Insurance..

Insurance Carrier_____City/phone_____

Subscriber name/ID#_____Group #_____

Do you have additional dental coverage? ○ Yes ○ No _____

Dental and Medical History..

Is the child currently under the care of a physician? ○ Yes ○ No If yes, for what reason? _____

Child's Primary Physician _____ Phone # _____

History of major illness? ○ Yes ○ No If yes, please describe_____

Any sensitivities or allergies? ○ Yes ○ No If yes, please list _____

Currently taking any medications? ○ Yes ○ No If yes, please list _____

Has puberty begun? ○ Yes ○ No Has there been any recent change in growth or clothing size? ○ Yes ○ No

Has menstruation (period) begun? ○ Yes ○ No ○ Not Applicable If yes, when? _____

Has the child been treated for any of the following?

☐ Arthritis ☐ Blood Disorder ☐ Diabetes ☐ Heart Condition ☐ Tuberculosis
☐ Asthma ☐ Cancer ☐ Epilepsy ☐ Nervous Disorder ☐ Other_____

Does the child receive regular dental care? ○ Yes ○ No When was the last check up? _____

Does the child tolerate routine dental procedures well? ○ Yes ○ No

Does the child require antibiotics before dental treatment? ○ Yes ○ No If yes, explain_____

Have the adenoids or tonsils been removed? ○ Yes ○ No

Have you been informed of extra or missing permanent teeth? ○ Yes ○ No

Have there been injuries to the child's face, mouth, teeth or chin? ○ Yes ○ No

Has the child had pain/tenderness in the jaw joint (TMJ/TMD)? ○ Yes ○ No

Does the child have any of the following habits?

☐ Speech Problems ☐ Chewing pens/pencils ☐ Chewing or Eating Difficulty
☐ Lip Biting ☐ Nail Biting ☐ Finger/Thumb Sucking (to what age? _____)
☐ Mouth Breather ☐ Grinding/Clenching ☐ Prolonged Bottle/Pacifier (to what age? _____)

Is there anything else that you feel we should know? _____

Signature..

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my child's medical status.
I authorize Dr. Linda Krebs' office to submit insurance claims on my behalf and release any information related to insurance claims. I consent to examination by the doctor and I authorize payment of any insurance benefits. The insured/patient authorizes the insurance company to pay the provider directly. All deductibles, co-payments, and denied claims will be the total responsibility of the patient.

Signature_____Date_____

Print Name _____ Relationship to patient_____