WELCOME

CHILD'S INFORMATION

Date_____ Kling Orthodontics, Inc. Page 1

Child's Name_____ Nickname _____

Male____ Female_____ Birthdate_____ Age_____ Home Phone_____

Child's Home Address_____ City_____ State____ Zip_____

School Child Attends_____ Grade_____

Whom may we thank for referring you?_____

PARENT'S / GUARDIAN'S INFORMATION

Mother_____ Step-Mother_____ Guardian_____

Name_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Email Address_____

Father_____ Step-Father_____ Guardian_____

Name_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Name of Nearest Relative (Not Living With You)_____

Street Address_____ City_____ State_____ Zip_____

Phone_____

Person Responsible for the account_____ Relationship_____

Street Address_____ City_____ State_____ Zip_____

Phone_____

DENTAL HISTORY

Patient's Name_____ Kling Orthodontics, Inc. Page 2

Patient's Dentist_____ Phone_____ Date of Last Visit_____

Yes **No** Does the patient require antibiotic therapy before dental treatment due to a heart condition?
Yes **No** Has the patient had any accidents requiring dental care?
Yes **No** Has the patient ever had any pain or tenderness in his/her jaw joint (TMJ / TMD)?
Yes **No** Has the patient ever been treated for periodontal disease?
Yes **No** Has the patient had root canal therapy?
Yes **No** Is the patient currently in pain?

Does / Did the patient have any of the following habits?

Y	**N**	Nail Biting	**Y**	**N**	Mouth Breather	**Y**	**N**	Clenching / Grinding Teeth
Y	**N**	Thumb Sucking	**Y**	**N**	Speech Problems	**Y**	**N**	Tongue Thrust

Medical History

Patient's Physician_____ Phone_____

Please list all medications that the patient is currently taking_____

Please list all substances that cause the patient allergic reactions_____

Please explain any serious medical problems (past or present)_____

Has the patient experienced any of the following:

Y	**N**	**Abnormal Bleeding**	**Y**	**N**	**Handicaps / Disabilities**	**Y**	**N**	**Mononucleosis**
Y	**N**	**ADHD / ADD**	**Y**	**N**	**Headaches**	**Y**	**N**	**Prosthetic Devices**
Y	**N**	**AIDS / HIV Positive**	**Y**	**N**	**Hearing Impairment**	**Y**	**N**	**Rheumatic Fever**
Y	**N**	**Allergies**	**Y**	**N**	**Heart Disease**	**Y**	**N**	**Scarlet Fever**
Y	**N**	**Anemia / Excessive Bleeding**	**Y**	**N**	**Heart Murmur**	**Y**	**N**	**Sickle Cell Anemia**
Y	**N**	**Arthritis**	**Y**	**N**	**Hemophilia**	**Y**	**N**	**Sinus Problems**
Y	**N**	**Asthma**	**Y**	**N**	**Hepatitis**	**Y**	**N**	**Skin Rashes / Hives**
Y	**N**	**Blood Transfusion**	**Y**	**N**	**High or Low Blood Pressure**	**Y**	**N**	**Thyroid Condition**
Y	**N**	**Bone Fractures**	**Y**	**N**	**Hospitalizations / Surgeries**	**Y**	**N**	**Tonsillitis**
Y	**N**	**Cancer**	**Y**	**N**	**Kidney Problems**	**Y**	**N**	**Tuberculosis**
Y	**N**	**Chicken Pox**	**Y**	**N**	**Liver Problems**	**Y**	**N**	**Ulcers**
Y	**N**	**Congenital Heart Defect**	**Y**	**N**	**Lupus**			
Y	**N**	**Diabetes**	**Y**	**N**	**Major Accidents**			
Y	**N**	**Epilepsy / Seizures**	**Y**	**N**	**Measles**			
Y	**N**	**Fainting Spells**	**Y**	**N**	**Mitral Valve Prolapse**			

Parent or Guardian Signature_____ Date_____ Doctor_____

Parent or Guardian Signature_____ Date_____ Doctor_____

Parent or Guardian Signature_____ Date_____ Doctor_____

ORTHODONTIC INSURANCE INFORMATION

PRIMARY

Insurance Company_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Insured's Name_____ Relationship to Patient_____

Birthdate_____ Social Security #_____ Group #_____

ID#_____ Insured's Employer_____

Employer Street Address_____ City_____ State_____ Zip_____

SECONDARY

Insurance Company_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Insured's Name_____ Relationship to Patient_____

Birthdate_____ Social Security #_____ Group #_____

ID#_____ Insured's Employer_____

Employer Street Address_____ City_____ State_____ Zip_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the above named patient(s) medical status. I authorize the dental staff to perform the necessary dental services the above named patient may need.

Signature_____ Date_____

I agree to be responsible for all charges for dental services and materials not a benefit of my dental plan. I authorize the release of any information relating to the dental benefit claim, and authorize payment of the dental benefit otherwise payable to me directly to Kling Orthodontics, Inc.

Signature_____ Date_____