



FOR CHILDREN: WELCOME TO OUR PRACTICE
Please Complete Thoroughly

PATIENT INFORMATION

Today's Date: _____ DOB: _____ Age: _____ M _____ F _____
Child's Name: (last) _____ (first) _____ Nickname: _____ SS#: _____
School: _____ Grade: _____ Patient Email: _____
Home Phone #: _____ Patient Cell #: _____
Home Address: _____ City: _____ Zip: _____
Present Dentist: _____ Date of last cleaning: _____ Phone Number: _____
Siblings names and ages: _____

WHO IS WITH THE CHILD TODAY

Name: _____ Relation: _____ Do you have legal custody of the child? Yes ___ No ___
Who may we thank for referring you? _____
Other family members seen by us? _____
Parent's marital status: Single ___ Married ___ Divorced ___ Re-Married ___ Widowed ___

MOTHER'S INFORMATION

Name: _____ SS#: _____ DOB: _____
Home Phone #: _____ Mother's Cell: _____ Mother's Email: _____
Home Address: _____ City: _____ Zip: _____ Yrs at Address: _____
Employer: _____ Work #: _____ Ext: _____
How long have you worked there? _____ Position: _____

FATHER'S INFORMATION

Name: _____ SS#: _____ DOB: _____
Home Phone #: _____ Father's Cell: _____ Father's Email: _____
Home Address: _____ City: _____ Zip: _____ Yrs at Address: _____
Employer: _____ Work #: _____ Ext: _____
How long have you worked there? _____ Position: _____

PRIMARY ORTHODONTIC INSURANCE

Insurance Name: _____ Phone #: _____
Insurance Company Address: _____
Insured's Name: _____ Relationship to Patient: _____
Group #: _____ ID/Policy #: _____

SECONDARY ORTHODONTIC INSURANCE

Insurance Name: _____ Phone #: _____
Insurance Company Address: _____
Insured's Name: _____ Relationship to Patient: _____
Group #: _____ ID/Policy #: _____

GENERAL INFORMATION

Has the child ever had a serious/difficult problem associated with dental work? Yes ___ No ___
 Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Yes ___ No ___
 Does the child brush teeth daily? Yes ___ No ___
 Does the child floss teeth daily? Yes ___ No ___
 Is the child currently under the care of a physician? Yes ___ No ___
 Child's Physician: _____ Phone #: _____ Last Visit: _____
 Please describe the child's health: _____ Good ___ Fair ___ Poor ___
 Please list all drugs the child is currently taking: _____
 Please list all drugs the child is allergic to: _____
 Does your child have any latex allergies? Yes ___ No ___

MEDICAL HISTORY

Heart Murm	Yes ___ No ___	Congenital Heart Def	Yes ___ No ___
Cancer	Yes ___ No ___	Convulsions/Epilepsy	Yes ___ No ___
Diabetes	Yes ___ No ___	Abnormal Bleeding	Yes ___ No ___
Rheum Fev	Yes ___ No ___	Hearing Impairment	Yes ___ No ___
HIV+/AIDS	Yes ___ No ___	Any Operations	Yes ___ No ___
Hemophilia	Yes ___ No ___	Any stays in Hospital	Yes ___ No ___
Asthma	Yes ___ No ___	Kidney/Liver Problems	Yes ___ No ___
Hepatitis	Yes ___ No ___	Handicaps/Disabilities	Yes ___ No ___
Tuberculosis	Yes ___ No ___	Allergies to Any Drugs	Yes ___ No ___
Prosthesis	Yes ___ No ___	History of Scarlet Fever	Yes ___ No ___

Please discuss any serious medical problems that the child has had: _____

Does the child have any of the following habits:

Thumb sucking/Finger sucking	Yes ___ No ___
Lip sucking/biting	Yes ___ No ___
Nail Biting	Yes ___ No ___
Nursing Bottle Habits	Yes ___ No ___

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA. I understand the information that 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. I also authorize the dental staff to perform the necessary dental services my child may need. I hereby authorize Orthobanc, LLC, on behalf of Frigo Orthodontics to obtain a copy of my credit report form from a credit reporting agency for the purpose of considering payment options.

Signature of Parent/Guardian

Date

The parent/guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved

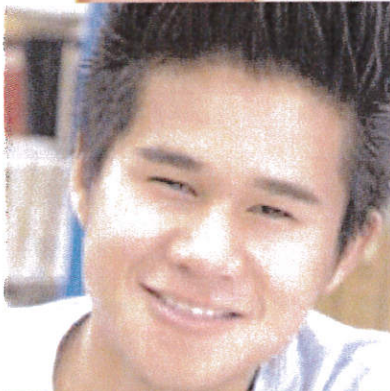
OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein:

Initials

Date

Doctor's Comments



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Our Goal is to...

Improve your child's life and help you address certain areas.

Poor 1 to Excellent 4

1. Rate your child's grades	1	2	3	4
2. Rate your child's attitude	1	2	3	4
3. Rate your child's leadership abilities	1	2	3	4
4. Rate your child's self-motivation	1	2	3	4
5. Rate your child's self-confidence	1	2	3	4
6. Rate your child's time management skills	1	2	3	4

What area do you feel that your child needs improving and that we can assist you.

Does your child wish to pursue an academic, athletic, cheer or dance scholarship?
