Larry A. Rose DDS, MS, Inc.

SPECIALIST IN ORTHODONTICS

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

invisalign

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Welcome to Our Practice!

Patient Information Form | For Children

About Your Child

PATIENT INFORMATION

Today's Date:_____

Best e-mail contact:_____

Child's Name: _____ Middle Initial:_____ Last Name:_____

Nickname: _____ DOB: _____ Age: _____ ☐ Male ☐ Female

School: _____ Grade:_____

Child's Home Address: _____ apt./unit/ste.: _____

City:_____ State: _____ Zip:_____ Home #: _____

RESPONSIBLE PARTY

First Name: _____ Middle Initial:_____ Last Name:_____

Billing Address:_____ City: _____ State: _____ Zip: _____

Home #:_____ Work #:_____ Ext #:_____ Cell #:_____

Employer: _____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS

Name: _____Work #: _____ Ext #: _____ Home #: _____ Cell #: _____

WHO IS THE CHILD WITH TODAY

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No Whom we may thank for referring you? _____

Other family members seen by us: _____ Parents' Marital Status: ☐ Single ☐ Married ☐ Divorced

Previous/Present Dentist: _____ Last Visit: _____ Street: _____ Phone #: _____

MOTHER'S INFORMATION

Name: _____Address: _____City:_____State: _____ Zip: _____

Work #: _____ Ext #: _____ Home #:_____ Cell #:_____

Employer: _____

FATHER'S INFORMATION

Name: _____Address: _____City:_____State: _____ Zip: _____

Work #: _____ Ext #: _____ Home #:_____ Cell #:_____

Employer: _____

Insurance Information

PRIMARY DENTAL INSURANCE

Ins. Name: _____

Claims Address: _____

Insurance Co. Phone #: _____

Group #: _____

Policy #:_____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB:_____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: ☐ Yes ☐ No

SECONDARY DENTAL INSURANCE

Ins. Name: _____

Claims Address: _____

Insurance Co. Phone #: _____

Group #: _____

Policy #:_____

Insured's Name: _____

Relationship to Patient: _____

Insured DOB:_____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: ☐ Yes ☐ No

OVER

Why did you bring the child to the Orthodontist today?

Has the child ever had serious/difficult problem associated with dental work? ☐ Yes ☐ No
Is the child water fluoridated? ☐ Yes ☐ No
Is the child taking fluoridated supplements? ☐ 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 Floss their teeth daily? ☐ Yes ☐ No
Child's Physician: _____ Phone #: _____ Last Visit: _____
Is the child currently under the care of a physician? ☐Yes ☐ No
Please describe child's health: ☐ Good ☐ Fair ☐ Poor
Please list all drugs the child is currently taking: _____

Please list all allergies to drugs or other materials: ☐ Latex ☐ Penicillin ☐ Other:_____

Has the child ever had any of the following medical problems?

☐Y ☐ N Heart Murmur	☐Y ☐ N Hemophilia	☐Y ☐ N Congenital Heart Def.	☐Y ☐ N Any Stays in Hospital
☐Y ☐ N Cancer	☐Y ☐ N Asthma	☐Y ☐ N Convulsions/Epilepsy	☐Y ☐N Kidney/Liver Problems
☐Y ☐ N Diabetes	☐Y ☐ N Hepatitis (A, B, C?)	☐Y ☐ N Abnormal Bleeding	☐Y ☐ N Handicaps/Disabilities
☐Y ☐ N Rheum. Fever	☐Y ☐ N Tuberculosis	☐Y ☐ N Hearing Impairment	☐Y ☐N History Of Scarlet Fever
☐Y ☐ N HIV+/AIDS	☐Y ☐ N Prosthesis	☐Y ☐ N Any Operations	

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

Does the child has any of the following habits?

☐Y ☐ N Thumb Sucking/ Finger Sucking ☐Y ☐ N Lip Sucking/Biting ☐Y ☐ N Nail Biting ☐Y ☐ N Nursing Bottle Habits

_____
DOCTOR CHECKED MEDICAL HISTORY DATE

Are there any health issues related to your child not fully addressed by the above questionnaire that you would like to discuss with the orthodontist? ☐Yes ☐No

I hereby give full permission and release from liability to Dr. Larry A. Rose and any other orthodontic associates who may be part of my treatment,Larry A. Rose, DDS, MS, Inc., and Houston Area Orthodontics concerning the display of photograph(s) of myself on the office bulletin board, on website(s), Face Book pages(s) associated with Dr. Larry A. Rose, Larry A. Rose, DDS, MS, Inc., Houston Area Orthodontics, or any other website(s) that may refer to Dr. Larry A. Rose. I understand that my first name may be used to identify the photograph, and reference may be made to treatment status (for example, starting treatment or having braces removed, etc.)

I understand the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment. I authorize the insurance company indicated on this form to pay to Larry A. Rose, DDS, MS, Inc. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Larry A. Rose, DDS, MS, Inc. to release all necessary information to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Payment is due in full at time of treatment unless prior arrangements have been approved.

Printed name of person signing:_____ Signature:_____ Date:_____

TO BE FILLED OUT BY THE ORTHODONTIST

LOWER ARCH: _____
UPPER ARCH: _____
CLASS:_____ MIDLINE:_____
OVERJET:_____ OVERBITE:_____
COMMENTS: _____
_____
_____
_____

OPTIONAL APPLIANCE: ☐Y ☐ N