Barbra J. Reed D.M.D., M.S., P.A

Practice Limited to Orthodontics
Phone: (239) 596-2255
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DATE OF EXAM:

Child's Information

NAME (LAST, FIRST, MI) | ☐ MALE ☐ FEMALE | AGE | DATE OF BIRTH

SCHOOL | GRADE | HOBBIES

CHILD LIVES WITH (CHECK ALL THAT APPLY)

☐ MOTHER ☐ STEPMOTHER ☐ GRANDMOTHER ☐ GUARDIAN ☐ FATHER ☐ STEPFATHER ☐ GRANDFATHER ☐ OTHER_____

Mother's Information

NAME (LAST, FIRST, MI) | ☐ MOTHER ☐ STEPMOTHER ☐ GRANDMOTHER | SOCIAL SECURITY NUMBER ___ ___

ADDRESS | HOME PHONE | DATE OF BIRTH

CITY, STATE, ZIP | EMAIL

EMPLOYER | HOW LONG | POSITION | WORK PHONE | CELL PHONE

Father's Information

NAME (LAST, FIRST, MI) | ☐ FATHER ☐ STEPFATHER ☐ GRANDFATHER | SOCIAL SECURITY NUMBER ___ ___

ADDRESS | HOME PHONE | DATE OF BIRTH

CITY, STATE, ZIP | EMAIL

EMPLOYER | HOW LONG | POSITION | WORK PHONE | CELL PHONE

Dental History

CHILDS DENTIST | DATE OF LAST EXAM

	YES	NO	COMMENTS:
Does child maintain 6 month dental check-ups?	☐	☐	
Do child's gums bleed while brushing?	☐	☐	
Does child clench or grind his/her teeth?	☐	☐	
Has your dentist suggested an orthodontic consultation?	☐	☐	
Has child ever had an orthodontic consultation?	☐	☐	
Has child ever had any orthodontic treatment?	☐	☐	

HOW DID YOU HEAR OF OUR OFFICE?

☐ DENTIST ☐ INSURANCE COMPANY ☐ NEWSPAPER ☐ PHONE BOOK
☐ TV/RADIO ☐ FRIEND_____ ☐ WEBSITE ☐ OTHER _____

NAMES OF ANYONE IN YOUR FAMILY WE HAVE SEEN:

Insurance Information

DO YOU HAVE ORTHO INSURANCE? ☐ YES ☐ NO

NAME OF INSURANCE COMPANY

PHONE NUMBER

INSURED'S NAME

☐ FATHER ☐ MOTHER ☐ _____

SOCIAL SECURITY NUMBER ___ ___

Financial Information

IF ORTHODONTIC TREATMENT IS NEEDED, WE CAN OFFER A CHOICE OF PAYMENT OPTIONS FOR FEES OVER $300 (PLEASE CHOOSE ONE)

☐ PAYMENT IN FULL (MASTERCARD, VISA, CASH, MONEY ORDER, CHECK) ☐ MONTHLY PAYMENTS - INTEREST FREE INSTALLMENT PAYMENT PLAN

NAME (LAST, FIRST, MI) OF PERSON RESPONSIBLE FOR PAYMENT

☐ FATHER ☐ MOTHER ☐ _____

SOCIAL SECURITY NUMBER ___ ___

ADDRESS

HOME PHONE

CITY

STATE

ZIP CODE

EMPLOYER

HOW LONG

POSITION

WORK PHONE

Medical Information

MEDICAL DOCTOR

DATE OF LAST EXAM

IS CHILD UNDER A DOCTOR'S CARE NOW? ☐ YES ☐ NO

FOR WHAT REASON?

HAS CHILD BEEN HOSPITALIZED IN THE LAST 5 YEARS? ☐ YES ☐ NO

FOR WHAT REASON?

HAS CHILD HAD TONSILS AND ADENOIDS REMOVED? ☐ YES ☐ NO

IF YES, WHEN?

IS CHILD ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO

IF YES, PLEASE LIST

IS CHILD TAKING ANY MEDICATION? ☐ YES ☐ NO

IF YES, PLEASE LIST

HAS CHILD EVER HAD:

	YES	NO
Asthma	☐	☐
Anemia	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Hepatitis or HIV/AIDS	☐	☐
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Abnormal Heart Condition	☐	☐
Abnormal Bleeding from a cut	☐	☐
Abnormal Blood Pressure	☐	☐

IS CHILD ALLERGIC TO:

	YES	NO
Penicillin	☐	☐
Local Anesthetic	☐	☐
Latex (Rubber Gloves)	☐	☐
Metals (ie. earrings)	☐	☐

X _____

By signing this form, I (Responsible Parent/Guarantor) confirm that the above information is true and accurate.

This acknowledges receipt of the "Notice of Privacy Practices".

COMMENTS