



MONTINI ORTHODONTICS

For Children:

Welcome to our office! Thank you for choosing us for your child's orthodontic needs. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to being a part in creating your child's new smile!

PATIENT INFORMATION

Date: _____ Social Security #: _____ Date of Birth: _____

Name of Minor / Child: _____ Sex: _____ Age: _____
Last Name First Name Middle Initial

Nickname: _____ Hobbies: _____

Home Address: _____
Street City State Zip

Cell Phone:(_____) _____ Home Phone:(_____) _____ Work Phone:(_____) _____

Whom may we thank for referring you?: _____

Other family members seen by us: _____ Their relation to you?: _____

School Name: _____ School Phone:(_____) _____

PARENTAL INFORMATION

Who is with the child today?: _____ Who is/are the legal guardian(s) of the child?: _____

Mother's Name: _____ Father's Name: _____

Address (if different from patient's) _____ Address (if different from patient's) _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Home Phone: (_____) _____ Work Phone: (_____) _____
(if different from above) (if different from above) (if different from above) (if different from above)

Email: _____ Email: _____

Employer: _____ Social Security #: _____ Employer: _____ Social Security #: _____

RESPONSIBLE PARTY INFO

Name: _____ Social Security #: _____

Billing Address: _____
Street City State Zip

Work Phone:(_____) _____ Home Phone:(_____) _____ Cell Phone:(_____) _____

Emergency Contact: _____ Their relation to you: _____

E.C. Home Phone:(_____) _____ E.C. Work Phone:(_____) _____ E.C. Cell Phone(_____) _____

DENTAL INSURANCE

Insurance Name: _____ Group/Policy #: _____

Insurance Address: _____
Street City State Zip

Insurance Co. Phone #:(_____) _____ Do you have secondary coverage: Yes No

Insured's Name: _____ Relationship to Patient: _____

Insured's DOB: _____ Insured's Employer: _____ SS#: _____

DENTAL HISTORY

General Dentist: _____ Date of Last Visit: _____ For What Services?: _____

Dentist Address: _____ Phone #:(_____)

	Yes	No		Yes	No
Has child complained about dental problems?	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form?	<input type="checkbox"/>	<input type="checkbox"/>
Does child brush teeth twice a day?	<input type="checkbox"/>	<input type="checkbox"/>	Any injuries to mouth, teeth, head?	<input type="checkbox"/>	<input type="checkbox"/>
Does child floss every day?	<input type="checkbox"/>	<input type="checkbox"/>	Any unhappy dental experiences?	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, grinding, clenching, etc.?	<input type="checkbox"/>	<input type="checkbox"/>			

Child's Dental Health: Good Fair Poor Has the child ever had any pain in the jaw joint (TMJ/TMD)?: Yes No

Child's Physician: _____ City/State: _____ Phone #:(_____)

MEDICAL HISTORY

	Yes	No	
Is the child currently under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	Medications: _____
Receiving any medications or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Allergies: _____
Is there excessive bleeding when cut?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you ever had any history of or difficulty with any of the following? If yes, please check.

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ |

AUTHORIZATION

To the best of my knowledge, the above is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent is covered by insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. Reid W. Montini all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize that use of my signature on all insurance submissions.

The above-named doctors may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

This consent will end when the current treatment plan in completed or one year from the date signed below.

Signature

Date

Please Print name of the Parent or Guardian

Date

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment?

If yes, please describe _____

Is patient taking any new medications: Yes No If yes, please list _____

Date: _____ Patient Signature: _____

Date: _____ Dentist Signature: _____