3007B Charlestown Crossing Way
New Albany, IN. 47150

Periago Orthodontics

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Floyds Knobs, IN. 47119

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www.periagoortho.com
(812) 944-5595

1985 Edsel Lane
Corydon, IN. 47112

Tell Us About Your Child

Today's Date ____/____/____ Nickname _____

Child's Name _____
LAST FIRST MI

Child's Birthdate ____/____/____ Child's Age _____ ☐ M ☐ F

Child's E-mail Address _____

School _____ Grade: _____

Hobbies/sports: _____

Child's Hm #: (_____) _____

Child's Home Address _____

_____
CITY STATE ZIP

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Y ☐ N

Whom may we thank for referring you? _____

Other siblings/ages: _____

_____

General Dentist: _____

Dentist Ph: (_____) _____ Last Visit Date: _____

Responsible Party Information

Who is responsible for account? _____ Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ Stepfather ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (_____) _____

_____

_____

Wk : (_____) _____ Cell #: (_____) _____

Email: _____

Employer: _____ Occupation: _____

Employer Address: _____

_____
CITY STATE ZIP

If you have orthodontic insurance coverage for the child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
CITY STATE ZIP

Ins. Ph : (_____) _____

Insured's ID # or Social Security #: _____

Group # (Plan, Local or Policy #): _____

☐ **Mother** ☐ Stepmother ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (_____) _____

_____

_____

Wk #: (_____) _____ Cell#: (_____) _____

Email: _____

Employer: _____ Occupation: _____

Employer Address: _____

_____
CITY STATE ZIP

If you have orthodontic insurance coverage for the child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
CITY STATE ZIP

Ins. Ph : (_____) _____

Insured's ID # or Social Security #: _____

Group # (Plan, Local or Policy #): _____

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

CONTINUED ON BACK

Dental and Medical History

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

Has you child ever been evaluated or had orthodontic treatment before? ☐ Y ☐ N

Have there been any injuries to the face, mouth, teeth or chin? ☐ Y ☐ N

Does the child require antibiotics before dental treatment? ☐ Y ☐ N

Have adenoids or tonsils been removed? ☐ Y ☐ N

Does your child have any missing or extra permanent teeth? ☐ Y ☐ N

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Y ☐ N

Does the child brush teeth daily? ☐ Y ☐ N Floss daily? ☐ Y ☐ N

Child's Physician: _____

Ph #: (_____)_____ Date of last visit:_____

Is the child currently under the care of a physician? ☐ Y ☐ N

Has puberty begun? ☐ Y ☐ N

GIRLS: Has menstruation begun? ☐ Y ☐ N

Indicate the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

_____ _____

_____ _____

Does your child have allergies to any of the following?

Latex ☐ Y ☐ N Nickel/Metals ☐ Y ☐ N Plastic ☐ Y ☐ N

Please list any other allergies that the child may have:

_____ _____

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Hearing Impairment
Y	N	ADD/ADHD	Y	N	Heart Murmur
Y	N	AIDS/HIV+	Y	N	Hemophilia
Y	N	Any Hospital Stays/Operations	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Problems
Y	N	Cancer	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Prosthetics
Y	N	Convulsions	Y	N	Rheumatic Fever
Y	N	Diabetes	Y	N	Scarlet Fever
Y	N	Epilepsy	Y	N	Sickle Cell Disease/Traits
Y	N	Handicaps/Disabilities	Y	N	Tuberculosis (TB)

Are the child's immunizations current? ☐ Y ☐ N

Would you like to discuss anything with the Doctor in private? ☐ Y ☐ N

Please list any serious medical problems the child has had:

_____

_____

_____

Does/did the child have any of the following habits?

Y	N	Clenching/Grinding Teeth	Y	N	Speech Problems
Y	N	Lip Sucking/Biting	Y	N	Thumb/Finger Sucking
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Pacifier Usage

List any musical instruments played: _____

_____

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

ORTHODONTIC INFORMATION RELEASE PER **HIPAA**

Patient Name: _____ Date of Birth: ____/____/____

I authorize the release of information including diagnosis, records, claims and financial information. This information may be released to:

_____ , _____ ,

_____ & _____ .

☐ I do not authorize the release of information to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/____

OFFICE USE ONLY

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

_____

SIGNATURE OF DOCTOR DATE

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If yes, please explain: _____

_____

Has there been any changes in your child's health status since their last visit? ☐ Y ☐ N

If yes, please explain: _____

_____

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

DOCTOR SIGNATURE DATE

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

DOCTOR SIGNATURE DATE