MATTESON ORTHODONTICS

Specialist in Orthodontics

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOUR CHILD

Date: _____ FirstName_____ Last_____

□ Female □ Male Nickname: _____

Child's birthdate: ____/____/_____ Child's age _____

School: _____ Grade: _____

Hobbies/sports: _____

Child's home phone #: (_____) _____-_____

Child's home address: _____

City: _____ State: _____ Zip: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing address: _____

City: _____ State: _____ Zip: _____

Work Phone#: (_____) _____- _____ Ext: _____

Cell Phone#: (_____) _____- _____

Where & when are the best times to reach you? _____

Employer: _____

SS# _____-_____-_____

DL# _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relation: _____

Do you have legal custody of this child: □ Yes □ No

Whom may we thank for referring you? _____

List brothers, sisters w/age: _____

_____

General dentist: _____

Last visit date: _____

Parent's marital status:

□ Single □ Widowed □ Married □ Divorced □ Separated

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage: □ Yes □ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. phone#: (_____) _____-_____

Group# (plan, local, or policy#): _____

Insured's Name: _____ Relation: _____

Insured's birthdate: _____/_____/_____

SS# or ID: _____

Insured's employer: _____

MOTHER'S INFORMATION

□ Mother □ Step Mother □ Guardian

Name: _____

Work Phone#: (_____) _____-_____ Ext:_____

Home Phone#: (_____) _____-_____

Employer: _____

SS#: _____-_____-_____ DL# _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage: □ Yes □ No

Insurance Co. Name: _____

Insurance Co. phone#: (_____) _____-_____

Group# (plan, local, or policy#): _____

Insured's Name: _____ Relation: _____

Insured's birthdate: _____/_____/_____

SS# or ID: _____

FATHER'S INFORMATION

□ Father □ Step Father □ Guardian

Name: _____

Work Phone#: (_____) _____-_____ Ext:_____

Home Phone#: (_____) _____-_____

Employer: _____

SS#: _____-_____-_____ DL# _____

E-MAIL ADDRESS

Name:_____

E-mail Address: _____

FORM CONTINUED ON BACK

4440 W. Lincoln Hwy Suite 300 ● Matteson, IL 60443 ● Phone (708) 481-6086 ● Fax (708) 481-2525

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODINTICS TO ACCOMPLISH?

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? □ Yes □ No

Have there been any injuries to the face, mouth, teeth or chin? □ Yes □ No

List any instrument played: _____
Have adenoids or tonsils been removed? □ Yes □ No
Has your child been informed of any missing teeth or extra permanent teeth? □ Yes □ No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? □ Yes □ No

Does your child brush his/her teeth daily? □ Yes □ No
Floss his/her teeth daily? □ Yes □ No

Is your child currently under the care of a physician?
□ Yes □ No
Child's Physician: _____
Phone#: (____) ___-_____ Date of last visit ___/__/___
Has puberty begun? □ Yes □ No
Please describe your child's current physical health:
□ Good □ Fair □ Poor

Please list all drugs that your child is currently taking:

_____

_____

Please list all drugs that your child is allergic to: _____

_____

_____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Allergic to plastic	Y N Allergic to latex/metals
Y N Heart murmur	Y N Congenital heart defect
Y N Cancer	Y N Convulsions/epilepsy
Y N Diabetes	Y N Abnormal bleeding
Y N Rheumatic fever	Y N Hearing impaired
Y N HIV+/AIDS	Y N Any operations
Y N Hemophilia	Y N Any stays in a hospital
Y N Asthma	Y N Kidney/liver problems
Y N Hepatitis/jaundice	Y N Handicaps/disabilities
Y N Tuberculosis (TB)	Y N Allergies to any drugs
Y N Blood transfusion	Y N Wears contact lenses
Y N Eye problems/glaucoma	Y N Thyroid disease
Y N High blood pressure	Y N Stomach ulcer
Y N Anemia	Y N Chronic cough

Please discuss any medical problems that your child has had:

_____

_____

_____

Name of relative not living with you that we may contact in case of emergency: _____
Phone #: (_____) _____-_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y N Thumb/finger sucking	Y N Mouth breather
Y N Lip sucking/biting	Y N Nail biting
Y N Clenching/grinding teeth	Y N Tongue thrust
Y N Nursing bottle habits	

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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.

_____ _____

Signature of Parent or Guardian Date

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

The parent or guardian who accompanies the child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

_____

Signature of Parent or Guardian Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein, initials_____ Date _____
Doctor's comments: _____