SALAITA ORTHODONTICS
PURSUING EXCELLENCE

PATIENT INFORMATION

Patient Name:____
LAST FIRST MI

Gender: Male ☐ Female ☐

Birthdate:________/________/________ Age:__________

Home Address:____

____
CITY STATE ZIP

Primary Phone Number: ______________________________

Name of School: ______________________ Grade: ______

Please list any sports and or extracurricular activities including musical instruments played:__________________

____

Siblings (Names & Ages) ______________________________

PARENT/GUARDIAN INFORMATION MATERNAL

Name:____
LAST FIRST MI

Relationship to Patient:
Mother ☐ Step-Mother ☐ Guardian ☐ Other ☐

Marital Status: S ☐ M ☐ D ☐ W ☐ SO ☐

Address (If different than patient):____________________

____
CITY STATE ZIP

Email:____

Primary Phone Number:______________________________

Occupation:____

Employer:____

PARENT/GUARDIAN INFORMATION PATERNAL

Name:____
LAST FIRST MI

Relationship to Patient:
Father ☐ Step-Father ☐ Guardian ☐ Other ☐

Marital Status: S ☐ M ☐ D ☐ W ☐ SO ☐

Address (If different than patient):____________________

____
CITY STATE ZIP

Email:____

Primary Phone Number:______________________________

Occupation:____

Employer:____

RESPONSIBLE PARTY FOR ACCOUNT

Name:____
LAST FIRST MI

Relationship to Patient:
Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐
Guardian ☐ Other ☐

Address (If different than patient):____________________

____
CITY STATE ZIP

Primary Phone Number:______________________________

Social Security #:________/________/________

Birthdate:________/________/________

PRIMARY DENTAL INSURANCE

Insurance Co. Name:________________________________

Insurance Co. Address: ______________________________

____
CITY STATE ZIP

Insurance Co. Phone:________________________________

Group #:____

Member ID #:______________________________________

Policy Holders Name:________________________________

Relationship to Patient:______________________________

Policy Holders SSN:________/________/________

Policy Holders Birthdate:________/________/________

Employer:____

SECONDARY DENTAL INSURANCE

Insurance Co. Name:________________________________

Insurance Co. Address: ______________________________

____
CITY STATE ZIP

Insurance Co. Phone:________________________________

Group #:____

Member ID #:______________________________________

Policy Holders Name:________________________________

Relationship to Patient:______________________________

Policy Holders SSN:________/________/________

Policy Holders Birthdate:________/________/________

Employer:____

(PLEASE COMPLETE BACK OF FORM)

SALAITA
ORTHODONTICS
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DENTAL HISTORY

General Dentist:______________________________ Phone:______________________________

What was the date of their last visit:_____/_____/_____

How did you hear about our practice? Advertisement ☐ Internet ☐ Family/Friend ☐ Dentist ☐ Other ☐

Whom may we thank for referring you (if applicable)? ______________________________

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

Has your child visited an orthodontist before? Yes ☐ No ☐If yes, date/reason:______________________________

Have we treated other family members? If yes, please list their names:______________________________

Has your child's Tonsils ☐ Adenoids ☐ been removed?

Has your child ever experienced pain/discomfort in their jaw joint (TMJ/TMD) Yes ☐ No ☐

If yes, please describe left/right or both. AM or PM:______________________________

Does your child have any missing or extra permanent teeth? Yes ☐ No ☐

Has your child ever had injury to the following: (Select all that apply) Teeth ☐ Jaw ☐ Chin ☐

Please describe injury:______________________________

Does your child have speech problems? Yes ☐ No ☐If yes, reason:______________________________

Do they currently or have they ever had any of the following habits: (Check all that apply)

Clenching/Grinding teeth: ☐ Lip Sucking/Biting: ☐ Thumb/Finger Sucking: ☐ Mouth Breathing: ☐

Tongue Thrusting: ☐ Nail Biting: ☐ Chewing/Eating Problem: ☐

MEDICAL HISTORY

Is your child currently under a physician's care? Yes ☐ No ☐ If yes, explain:______________________________

Physician:______________________________ Phone:______________________________

What was the date of their last visit:_____/_____/_____

Does your child have any allergies or sensitivities? (ie medication, latex, nickel, etc) Y☐ N ☐ If yes, explain:__________

Is your child taking any medications at this time? Yes ☐ No ☐ If yes, explain:______________________________

Has puberty (males) or menstruation (females) begun? Yes ☐ No ☐

Has your child had any serious illnesses or operations? Yes ☐ No ☐ If yes, explain:______________________________

Has your child ever had a blood transfusion? Yes ☐ No ☐ If yes, explain:______________________________

Please check if your child has ever had any of the following:

☐ ADD/ADHD	☐ Cancer	☐ Epilepsy	☐ Hepatitis	☐ Radiation Treatment	☐ Thyroid Problems
☐ Anemia	☐ Chemotherapy	☐ Fainting	☐ High Blood Pressure	☐ Respiratory Disease	☐ Tonsillitis
☐ Arthritis, Rheumatism	☐ Circulatory Problems	☐ Glaucoma	☐ HIV/AIDS	☐ Rheumatic Fever	☐ Tuberculosis
☐ Artificial Heart Valves	☐ Cortisone Treatments	☐ Headaches	☐ Kidney Disease	☐ Scarlet Fever	☐ Ulcer
☐ Artificial Joints	☐ Cough, Persistent	☐ Heart Murmur	☐ Liver Disease	☐ Shortness of Breath	☐ Venereal Disease
☐ Asthma	☐ Coughing Blood	☐ Heart Problems	☐ Mitral Valve Prolapse	☐ Stroke	☐ Other
☐ Blood Disease	☐ Diabetes	☐ Hemophilia	☐ Pacemaker	☐ Swelling of Feet or Ankles	

AUTHORIZATION - PLEASE SIGN & DATE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's medical status. I hereby authorize the release of any information pertaining to my child's dental treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

Signature:______________________________ Date:______________________________