ALL ★ STAR
FAMILY ORTHODONTICS

Welcome to your Orthodontist!

3331 US Highway 9, Old Bridge, NJ 08857 (732) 727-6666

TELL US ABOUT YOUR CHILD

Today's Date: ____/____/____ ❑ Male ❑ Female

CHILD'S NAME: _____
First M Last

Nickname: _____ Child's Home #: (____) _____

Date of Birth: ____/____/____ Age: ____

School: _____ Grade: _____

Hobbies/Sports: _____

Home Address: _____
Street Address Apt/Condo #

_____
CITY STATE ZIP

E-Mail Address: _____

GENERAL INFORMATION

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 with age: _____

_____

General Dentist: _____

Dentist's Phone: _____

Relative or Friend not living with you:

Name: _____ Phone: (____) _____

Address: _____

_____

PARENT'S / GUARDIAN'S INFORMATION

Who is responsible for account: _____ Status: ❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Divorced ❑ Separated

❑ **Father** ❑ Step Father ❑ Guardian ❑ Grandfather ❑ Uncle

Name: _____ Birthdate: ____ / ____ / ____

Address (if different from Child's):

_____

_____

SS#: _____ Home Phone #: _____

Work #: _____ ext. _____ Mobile #: _____

Email: _____

Employer: _____

Employer's Address: _____

_____

Occupation: _____

If your have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone #: _____ Policy #: _____

❑ **Mother** ❑ Step Mother ❑ Guardian ❑ Grandmother ❑ Aunt

Name: _____ Birthdate: ____ / ____ / ____

Address (if different from Child's):

_____

_____

SS#: _____ Home Phone #: _____

Work #: _____ ext. _____ Mobile #: _____

Email: _____

Employer: _____

Employer's Address: _____

_____

Occupation: _____

If your have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone #: _____ Policy #: _____

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 manula or electronic.

AUTHORIZATION

_____ _____
Signature of Parent or Guardian Date

HEALTH HISTORY

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

_____

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

Has your child ever had an injury to: ❑ Face ❑ Mouth ❑ Teeth ❑ Chin

List any musical instruments played? _____

Has your child been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has you 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

Child's Physician:_____

Phone #: (_____)_____ Date of last visit: ____/____/____

Is your child currently under the care of a physician? ❑ Yes ❑ No

Has puberty begun? ❑ Yes ❑ No

Has menstruation begun? (Girls) ❑ Yes ❑ No

If yes, when was menstrual?

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/things that your child is allergic to:

_____

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

Abnormal Bleeding	❑ Yes ❑ No	Handicaps/Disabilities	❑ Yes ❑ No
ADD /ADHD	❑ Yes ❑ No	Hearing Impairment	❑ Yes ❑ No
Allergies to any Drugs	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No
Allergic to Latex/Metals	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No
Allergic to Plastic	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No
Any Hospital Stays	❑ Yes ❑ No	HIV+/AIDS	❑ Yes ❑ No
Any Operations	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No
Artificial Bones/Joints/Valves	❑ Yes ❑ No	Liver Problems	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Lupus	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Rheumatic/Scarlet Fever	❑ Yes ❑ No
Congenial Heart Defect	❑ Yes ❑ No	Sickle Cell Disease/Traits	❑ Yes ❑ No
Convulsions/Epilepsy	❑ Yes ❑ No	Tuberculosis (TB)	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No		

Please discuss any medical problems that your child had:

_____

_____

_____

DOES/DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

Clenching/Grinding Teeth	❑ Yes ❑ No
Lip Sucking/Biting	❑ Yes ❑ No
Mouth Breather	❑ Yes ❑ No
Nail Biting	❑ Yes ❑ No
Nursing Bottle	❑ Yes ❑ No
Speech Problems	❑ Yes ❑ No
Thumb/Finger Sucking	❑ Yes ❑ No
Tongue Thrust	❑ Yes ❑ No
Was your child breast fed?	❑ Yes ❑ No

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 authorize the dental staff to perform the necessary dental services my child may need.

_____

SIGNATURE OF PARENT OR GUARDIAN: DATE

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 the office, use the services of one or more credit reporting services.

_____

SIGNATURE DATE

I authorize payment of dental benefits in accordance with my current insurance policy to All Star Family Orthodontics for professional services rendered. I understand that I am responsible for the payment and also responsible for any co-payment and deductibles that my insurance does not cover.

_____

SIGNATURE DATE

The Parent or Guardian who accompanies the child is responsible for payment.

I acknowledge that I have received a notice of Privacy Practices from All Star Family Othodontics.

_____

SIGNATURE DATE

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

OFFICE USE ONLY

I verbally reviewed the medial/dental information above with the patient named herein.

Initials: _____ Date: ____/____/____

Doctors Comments:

_____

_____

Although the initial consultation is complimentary, if records are required we will bill your insurance company. You will not be responsible for uncovered portion.

_____ _____

Signature Date