

Questionnaire

PC - Welcome Information – Child

Child Information Sheet

WELCOME TO PARK CITIES ORTHODONTICS

PLEASE FILL IN EACH OF THE FOLLOWING BOXES WITH THE CORRECT INFORMATION

THIS FORM IS HIPAA COMPLIANT TO ENSURE PRIVACY

PATIENT INFORMATION

PATIENT'S FIRST NAME: _____ LAST NAME: _____
PATIENT'S PREFERRED NAME: _____ SEX: _____ FEMALE MALE
DATE OF BIRTH: _____ AGE IN YEARS: _____
PATIENT'S CELL PHONE: _____ PATIENT'S HOME PHONE: _____
PATIENT'S EMAIL: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
I PREFER OFFICE COMMUNICATION VIA? TEXT EMAIL BOTH
LIST NAME AND BIRTHDATE OF CHILDREN
NAME: _____ BIRTHDATE: _____
NAME: _____ BIRTHDATE: _____
HOBBIES/SPORTS/ACTIVITIES/MUSICAL INSTRUMENTS? _____
HAS PATIENT EVER BEEN SEEN FOR ANY OTHER ORTHODONTIC CONSULTATION? _____
IF YES - ORTHODONTIST NAME: _____ DATE OF VISIT: _____
HAS PATIENT EVER HAD PREVIOUS ORTHODONTIC TREATMENT? _____
IF YES - ORTHODONTIST NAME: _____ HOW LONG AGO WAS TREATMENT? _____

MOTHER'S INFORMATION

MOTHER'S FIRST NAME: _____ MOTHER'S LAST NAME: _____
DATE OF BIRTH: _____ SOCIAL SECURITY: _____
EMPLOYED BY: _____ OCCUPATION: _____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____
WHICH PHONE # IS THE BEST TO REACH RESPONSIBLE PARTY AT? CELL HOME WORK
EMAIL ADDRESS: _____

FATHER'S INFORMATION

FATHER'S FIRST NAME: _____ FATHER'S LAST NAME: _____
DATE OF BIRTH: _____ SOCIAL SECURITY: _____
EMPLOYED BY: _____ OCCUPATION: _____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____
WHICH IS THE BEST PHONE # TO REACH SPOUSE AT? CELL HOME WORK
EMAIL ADDRESS: _____

PARENTS ARE: SINGLE MARRIED WIDOWED DIVORCED SEPERATED
CUSTODIAL PARENT: _____
FINANCIAL RESPONSIBLE: MOTHER FATHER OTHER: _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____ PHONE: _____
PHYSICIAN NAME: _____ PHONE: _____

REFERRAL INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
DENTIST FAMILY FRIENDS DRIVE BY WEBSITE OTHER: _____
YOUR REFERRAL'S NAME (FIRST AND LAST): _____
HAS ANYONE IN YOUR FAMILY HAD ORTHODONTIC TREATMENT IN OUR OFFICE? YES NO
IF YES...WHO? (FIRST/LAST NAMES AND RELATIONSHIP TO PATIENT): _____

PRIMARY INSURED INFORMATION

NAME OF PRIMARY INSURED* (As it appears on the insurance card): _____
PRIMARY INSURED'S DATE OF BIRTH: _____
PRIMARY INSURED'S SSN / MEMBER ID#: _____
PRIMARY INSURED'S RELATIONSHIP TO PATIENT: MOM DAD GUARDIAN STEPMOM STEPDAD GRANDPARENT
STREET ADDRESS OF THE INSURED: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURED'S EMPLOYER: _____

NAME OF PRIMARY DENTAL INSURANCE COMPANY: _____

PRIMARY INSURANCE GROUP: _____

PRIMARY INSURANCE COMPANY'S STREET ADDRESS: _____

PRIMARY INSURANCE CITY: _____ PRIMARY INSURANCE STATE: _____

PRIMARY INSURANCE ZIP: _____ PRIMARY INSURANCE COMPANY PHONE: _____

SECONDARY INSURED INFORMATION

NAME OF SECONDARY INSURED* (As it appears on the insurance card): _____

SECONDARY INSURED'S DATE OF BIRTH: _____

SECONDARY INSURED'S SSN / MEMBER ID: _____

SECONDARY INSURED'S RELATIONSHIP TO PATIENT: MOM DAD GUARDIAN STEPMOM STEPDAD GRANDPARENT

STREET ADDRESS OF THE INSURED: _____

CITY: _____ STATE: _____ ZIP: _____

SECONDARY INSURED'S EMPLOYER: _____

NAME OF SECONDARY DENTAL INSURANCE COMPANY: _____

SECONDARY INSURANCE GROUP: _____

SECONDARY INSURANCE COMPANY'S STREET ADDRESS: _____

SECONDARY INSURANCE CITY: _____ SECONDARY INSURANCE STATE: _____

SECONDARY INSURANCE ZIP: _____ SECONDARY INSURANCE COMPANY PHONE: _____

DENTAL HISTORY RECORD

DENTIST'S FIRST AND LAST NAME: _____ DENTIST'S PHONE: _____

DATE OF LAST DENTAL APPT: _____

ANY CURRENT DENTAL TREATMENT RECOMMENDED BY YOUR DENTIST? _____

IF YES, EXPLAIN: _____

CHECK ALL REASONS FOR SEEKING ORTHODONTIC CONSULTATION:

FRONT TEETH PROTRUDING OVERBITE / UNDERBITE CROWDED TEETH

JAW PAIN SPACES BETWEEN TEETH OTHER

DID YOUR DENTIST ENCOURAGE YOU TO SEEK AN ORTHODONTIC CONSULTATION? YES NO

HAVE YOU EVER HAD ANY DIFFICULTY WITH PAST DENTAL TREATMENT? YES NO

YOUR CURRENT DENTAL HEALTH IS? GOOD FAIR POOR

DO YOU HAVE ANY MISSING OR EXTRA TEETH? YES NO

HAVE YOU EVER BEEN TOLD THAT YOU HAVE "GUM" PROBLEMS? YES NO

HAVE YOU EVER EXPERIENCED BLEEDING GUMS/BAD TASTE OR MOUTH ODOR? YES NO

HAVE YOU EVER HAD AN INJURY TO YOUR FACE, NECK, JAWS OR TEETH? YES NO

IF YES EXPLAIN: _____

HAVE YOU EVER HAD A FRACTURED JAW / CYSTS / INFECTION? YES NO

IF YES EXPLAIN: _____

DO YOU HAVE DIFFICULTY IN CHEWING/ OPENING YOUR JAW OR RINGING IN EARS? YES NO

DO YOUR JAWS EVER CLICK OR POP? YES NO

HAVE YOU EVER HAD ANY PAIN OR TENDERNESS IN YOUR JAW JOINT? YES NO

DO YOU HAVE PRE-EXISTING TMJ PROBLEMS? YES NO

ANY SENSITIVE OR SORE TEETH? YES NO

IF YES EXPLAIN: _____

PLEASE MARK IF YOU HAVE/OR HAD ANY OF THE FOLLOWING HABITS.

NAIL BITING NIGHT GRINDING LIP BITING THUMB OR FINGER SUCKING PENCIL BITING MOUTH BREATHING

TONGUE THRUST OTHER: _____

ARE YOU HAPPY WITH YOUR SMILE? YES NO

ARE YOU INTERESTED IN: TRADITIONAL (metal) BRACES CLEAR (ceramic) BRACES INVISALIGN RETAINERS

MEDICAL HISTORY RECORD

Your health is important to us. In order to provide excellent care with safety, it is necessary to become acquainted with vital information related to each patient. Thus, it is extremely important that you answer the following questions as accurately as possible. If you have any questions regarding the information requested, please feel free to ask the doctor or a member of the staff for assistance.

HAVE YOU BEEN A PATIENT IN A HOSPITAL DURING THE PAST 2 YEARS? YES NO

HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN THE PAST 2 YEARS? YES NO

HAVE YOU TAKEN ANY KIND OF MEDICINE OR DRUGS DURING THE PAST YEAR? YES NO

ARE YOU CURRENTLY TAKING/OR HAVE YOU EVER TAKEN ORAL OR INTRAVENOUS BISPHTHOSPHONATES FOR SERIOUS BONE DISORDERS/CANCERS, SUCH AS ZOMETA (ALENDRONATE), AREDIA (PARMIDRONATE), DIDRONEL (ETODRONATE). OSTEOPOROSIS, OSTEOPENIA, FOSAMAX, (ALENDRONATE), ACTONEL (RISENDRONATE), BONIVA (IBANDRONATE), SKELID (TILUDRONATE)? YES NO

If yes, describe: _____
 PLEASE LIST THE MEDICATIONS: _____
 DO YOU SMOKE? YES - How Much? _____ NO
 WOMEN: ARE YOU PREGNANT / IS THERE A POSSIBILITY YOU ARE PREGNANT? YES - NO HOW MANY MONTHS? _____
 DO YOU SUFFER FROM FREQUENT OR SEVERE HEADACHES, NECK OR BACK PAIN? YES NO
 IF YES EXPLAIN: _____
 HAVE YOU HAD ANY OTHER SERIOUS ILLNESSES? YES NO
 IF YES EXPLAIN: _____

Have you ever had any of the following diseases or medical problems. Please mark YES or NO .

HEMOPHILIA/ABNORMAL BLEEDING:	YES NO	ANEMIA:	YES NO
ASTHMA:	YES NO	AIDS / HIV+:	YES NO
ARTHRITIS:	YES NO	AUTISM/ASPERGERS:	YES NO
CANCER / CHEMOTHERAPY/RADIATION:	YES NO	DIABETES:	YES NO
DRUG / ALCOHOL ABUSE:	YES NO	EPILEPSY / SEIZURES / FAINTING:	YES NO
FIBROMYALGIA:	YES NO	HEARING IMPAIRMENT:	YES NO
HEART ATTACK / STROKE:	YES NO	HEART MURMUR/HEARTDISEASE:	YES NO
HEART SURGERIES/HEART PACEMAKER:	YES NO	HEPATITIS:	YES NO
HIGH / LOW BLOOD PRESSURE:	YES NO	KIDNEY PROBLEMS:	YES NO
MITRAL VALVE PROLAPSE:	YES NO	RHEUMATIC / SCARLET FEVER:	YES NO
PAIN/PRESSURE/TIGHTNESS IN CHEST:	YES NO	PSYCHIATRIC/LEARNING/ADHD:	YES NO
SINUS/BREATHING PROBLEMS:	YES NO	SPEECH PROBLEMS:	YES NO
TONSILS/ADENOIDS REMOVED:	YES NO	TUBERCULOSIS:	YES NO

ANY MAJOR OPERATIONS?: YES NO IF YES EXPLAIN: _____
 IS ANTIBIOTIC PREMEDICATION REQUIRED BEFORE DENTAL PROCEDURES?: YES NO EXPLAIN: _____

ARE YOU ALLERGIC TO :

Please mark YES or NO for the following allergies

ANY METALS/PLASTICS: YES NO	CODEINE: YES NO	DENTAL ANESTHETICS: YES NO
UNKNOWN LATEX: YES NO	PENICILLIN: YES NO	TETRACYCLINE: YES NO

LIST ANY OTHER ALLERGIES: _____

NOW OR IN THE PAST, HAVE YOU HAD?

BIRTH DEFECT OR HEREDITARY PROBLEMS:	YES NO	BONE FRACTURES OR MAJOR INJURIES:	YES NO
ANY INJURIES TO THE FACE, HEAD OR NECK:	YES NO	MENTAL HEALTH DISTURBANCE OR DEPRESSION:	YES NO
HISTORY OF EATING DISORDERS:	YES NO	EXCESSIVE BLEEDING OR BRUISING, ANEMIA:	YES NO
ANGINA, ARTERIOSELEROSIS, STROKE, OR HEART ATTACK:	YES NO	FREQUENT HEADACHES OR MIGRAINS:	YES NO
SKIN DISORDER (OTHER THAN COMMON ACNE):	YES NO	INFECTIOUS:	YES NO
FREQUENT EAR INFECTIONS, COLDS THROAT:	YES NO		

PLEASE RATE THE FOLLOWING CONCERNS FOR THE PATIENT AND/OR RESPONSIBLE PARTY:

Fear of Pain:	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
Fear of Dentists:	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
Trust in Dentists:	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
Financial Concerns:	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
Need for Treatment:	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE

NAME OF PERSON FILLING OUT THIS FORM: _____

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE RIGHT TO REVIEW THIS OFFICE'S NOTICE OF PRIVACY PRACTICES (HIPAA). A COPY OF THIS NOTICE CAN BE VIEWED ON OUR WEBSITE WWW.PC-ORTHO.COM OR A PHYSICAL HARD COPY CAN BE OBTAINED UPON REQUEST IN OUR OFFICE.

I CERTIFIED THAT I HAVE READ AND UNDERSTAND THE ABOVE. I AFFIRM THAT THE INFORMATION CONTAINED IN THIS FORM AND ANY ADDITIONAL INFORMATION THAT I MAY FURNISH IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I WILL NOT HOLD DR. TIEN NGUYEN AND OR THE STAFF OF PARK CITIES ORTHODONTICS RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

PLEASE TYPE YOUR NAME AND DATE BELOW BEFORE SUBMITTING
 OR THIS FORM WILL NOT SUBMIT TO US

PATIENT/GUARDIAN PRINTED NAME: _____ DATE: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____