Welcome to Mongiovi 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: __/__/____ ☐ Male ☐ Female

Child's Name:_____

Nickname:_____ Age:___ Date of Birth: __/__/____

School:_____ Grade:_____

Hobbies/Sports:_____

Child's Home #:_____

Child's Home Address:_____

_____

Parent/Guardian Information

Mother's Information:

☐ Mother ☐ Guardian ☐ Step-Mother

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

Address (if different from patients):_____

_____

Employer: _____ Title:_____

Employer Address: _____

Work #: _____ Cell #: _____

Email Address:_____

How long at current job?:_____ SSN: _____-_____-_____

Who is accompanying your child today?

Name:_____ Relation:_____

Whom may we thank for referring you?: _____

Siblings Names with Ages:_____

General Dentist:_____ Last visit date: __/__/____

Parents Martial Status: ☐ Single ☐ Married

☐ Divorced ☐ Widowed ☐ Separated

If divorced or separated, who has custody of the child?:

_____

Father's Information:

☐ Father ☐ Guardian ☐ Step-Father

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

Address (if different from patients):_____

_____

Employer: _____ Title:_____

Employer Address: _____

Work #: _____ Cell #: _____

Email Address:_____

How long at current job?:_____ SSN: _____-_____-_____

Responsible Party: Please designate one parent/guardian who will take responsibility for scheduling visits, financial obligations, and insurance coverage, and will also participate in home care instructions.

Name:_____

Relation:_____

Address (if different from patients):_____

_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Email:_____

In case of an emergency, whom do we contact?

Name:_____ Relation: _____ Phone #: _____

Insurance Information

Primary Insurance: **Dental Coverage?** ☐ Yes ☐ No Orthodontic Coverage**?** ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address:_____

_____

Phone #: _____ Group #: _____

Policy Owner Name: _____

Date of Birth: ____/____/____ SSN: _____-_____-_____

Is there any secondary Insurance? If so, please note information below:

Continued on next page

Medical History

Patient's General Health: ☐ Good ☐ Fair ☐ Poor

Name of Physician:_____

Date of last visit: ____ /____ /____ Has puberty begun?_____

Is the patient currently under the care of a physician?

☐ Yes ☐ No If yes, please explain:_____

_____

Please list all medications your child is currently taking:_____

_____

Please list any drug or non-drug allergies: _____

Is the patient allergic to any of the following? (please check)

☐ Metals ☐ Plastics ☐ Latex ☐ Penicillin ☐ Antibiotics

☐ Dental Anesthetics ☐ Other:_____

Dental History

- Has the patient ever been evaluated or had orthodontic treatment before?: ☐ Yes ☐ No
- Have there been any injuries to the face, mouth, teeth or chin?: ☐ Yes ☐ No
- Have you been informed of any missing or extra permanent teeth?: ☐ Yes ☐ No
- Does the patient have any pain or tenderness in the jaw joint (TMJ/TMD)?: ☐ Yes ☐ No
- Does the patient have any speech problems?: ☐ Yes ☐ No
- Does the patient currently have a thumb or finger sucking habit?: ☐ Yes ☐ No
- How often does the patient brush his/her teeth daily?

  _____
- What are the main concerns you would like orthodontics to accomplish?:_____

Please check Yes ('Y') or No ('N') whether your child has a history of the following:

☐ Y	☐ N	Abnormal bleeding	☐ Y	☐ N	Handicaps/Disabilities	☐ Y	☐ N	Tuberculosis
☐ Y	☐ N	ADD/ADHD	☐ Y	☐ N	Hearing Impairment	☐ Y	☐ N	Venereal Disease
☐ Y	☐ N	Anemia	☐ Y	☐ N	Heart Attack	☐ Y	☐ N	Epilepsy/Seizures
☐ Y	☐ N	Arthritis	☐ Y	☐ N	Heart Murmur	☐ Y	☐ N	Mitral Valve Prolapse
☐ Y	☐ N	Artificial Bones/Joints	☐ Y	☐ N	Heart Surgery/Pacemaker	☐ Y	☐ N	Ever been hospitalized?
☐ Y	☐ N	Asthma/Diff. Breathing	☐ Y	☐ N	Hepatitis			
☐ Y	☐ N	Back Problems	☐ Y	☐ N	High/Low Blood Pressure			
☐ Y	☐ N	Blood Disease	☐ Y	☐ N	HIV+/AIDS			
☐ Y	☐ N	Blood Transfusion	☐ Y	☐ N	Kidney/Liver Problems			
☐ Y	☐ N	Cancer/Chemotherapy	☐ Y	☐ N	Psychiatric Problem			
☐ Y	☐ N	Congenital Heart Defect	☐ Y	☐ N	Rheumatic/Scarlet Fever			
☐ Y	☐ N	Diabetes	☐ Y	☐ N	Severe/Frequent Headaches			
☐ Y	☐ N	Drug/Alcohol Abuse	☐ Y	☐ N	Shingles			
☐ Y	☐ N	Emphysema	☐ Y	☐ N	Sickle Cell Disease/Trait			
☐ Y	☐ N	Fainting Spells	☐ Y	☐ N	Sinus Problems			
☐ Y	☐ N	Fever Blisters/Herpes	☐ Y	☐ N	Thyroid Disease/Malfunc.			
☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Tonsils/Adenoids Removed			

Please provide additional information if you checked YES to any of the above:

I understand that the information that I have given is correct, to the best of my knowledge, and that it will be held in the strictest of confidence. I understand that it is my responsibility to inform this office of any changes in the patient's medical status. A copy of the office's HIPPA policy is posted and I understand my rights and the office's procedures as stated in the policy. A personal copy is available upon my request. During today's visit, and subsequent Recall visits, I understand that the Doctor will provide Orthodontic treatment recommendations. I understand that there are risks associated with any Orthodontic treatment plan. I understand that I am always welcome to review the treatment recommendations with the Doctor and to voice any concerns that I may have.

I hereby consent to the making of diagnostic records, including x-rays and give consent to the Doctor and his staff to provide orthodontic treatment prescribed by the Doctor for the patient. I hereby authorize the Doctor to provide other health care providers with information regarding the patient as deemed appropriate. I understand that once released, the Doctor and his staff have no responsibility for any further release by the individual receiving this information.

Parent/Guardian Signature:_____ Date: ____ /____ /____

OFFICE USE ONLY

Doctor's Comments: _____

Doctor's Signature: _____ Date: ____ /____ /____