William G. Horbaly, D.D.S., M.S., M.D.S.

ORTHODONTIST

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Please Tell Us About Your Child

Today's Date: ______________ ☐ Male ☐ Female

Child's Name: ________________ (LAST) ________________ (FIRST) ____ (MI) Nickname: ______________ SS #: ______________

Birthdate: _____ / _____ / _____ Age: _______ School: ______________________ Grade: __________

Hobbies / Sports: ______________________________ Home #: (_____) ______________

Home Address: ______________ APT/CONDO # ______________ CITY ______________ STATE ______ ZIP ______

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: ______________________ Last Visit Date: ____________ Last Cleaning Date: ____________

Parent's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Mother's Information

Name: ______________________ ☐ Step Mother ☐ Guardian Birthdate: _____ / _____ / _____

Work #: (_____) ______________ Ext: _______ Home #: (_____) ______________

Employer: ______________________________

How Long at Current Job: __________ Job Title: ______________ SS #: ______________ DL #: ______________

Father's Information

Name: ______________________ ☐ Step Father ☐ Guardian Birthdate: _____ / _____ / _____

Work #: (_____) ______________ Ext: _______ Home #: (_____) ______________

Employer: ______________________________

How Long at Current Job: __________ Job Title: ______________ SS #: ______________ DL #: ______________

Person Responsible for Account

Name: ______________________________ Relation: ______________

Billing Address: ______________ CITY ______________ STATE ______ ZIP ______ Previous Address: ______________ CITY ______________ STATE ______ ZIP ______

Home #: (_____) ______________ Work #: (_____) ______________ Ext: _______

Employer: ______________________ SS #: ______________ DL #: ______________

Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No Insurance Co. Name: ______________________ Phone #: (_____) ______________

Insurance Co. Address: ______________________ Group # (Plan, Local, or Policy #): ______________

Policy Owner's Name: ______________________ Relationship to Patient: ______________

Policy Owner's Birthdate: _____ / _____ / _____ SS #: ______________ **Policy Owner's** Employer: ______________

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No Insurance Co. Name: ______________________ Phone #: (_____) ______________

Insurance Co. Address: ______________________ Group # (Plan, Local, or Policy #): ______________

Policy Owner's Name: ______________________ Relationship to Patient: ______________

Policy Owner's Birthdate: _____ / _____ / _____ SS #: ______________ **Policy Owner's** Employer: ______________

CONTINUED ON BACK

What are the main concerns that you would like orthodontics 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 musical instruments played: ____________

Have adenoids or tonsils been removed? ☐Yes ☐No / Has your child been informed of any missing or extra permanent teeth? ☐Yes ☐No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMDJ)? ☐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: ____________

Has puberty begun? ☐Yes ☐No / Has menstruation begun? (Girls) ☐Yes ☐No

Child's Height ________ Mother's Height ________ Father's Height ________

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?

Y	N	Abnormal Bleeding	Y	N	Any Operations	Y	N	Diabetes	Y	N	Hepatitis
Y	N	Allergies to any Drugs	Y	N	Asthma	Y	N	Handicaps/Disabilities	Y	N	HIV+/AIDS
Y	N	Allergic to Latex/Metals	Y	N	Cancer	Y	N	Hearing Impairment	Y	N	Kidney/Liver Problems
Y	N	Allergic to Plastic	Y	N	Congenital Heart Defect	Y	N	Heart Murmur	Y	N	Rheumatic/Scarlet Fever
Y	N	Any Hospital Stays	Y	N	Convulsions/Epilepsy	Y	N	Hemophilia	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had: ____________

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Does/did your child have any of the following habits?

Y	N	Clenching/Grinding Teeth	Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Speech Problems	Y	N	Thumb/Finger Sucking			

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, including photographs and x-rays. I consent for the photographs and x-rays to be used by the doctor in scientific papers or presentations.

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

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SIGNATURE OF PARENT OR GUARDIAN DATE

You will be responsible for payment of services rendered and for paying any co-payment and deductibles that your insurance does not cover. As a courtesy, our office will file your insurance claim; however, should problems arise, you will be responsible for contacting your insurance company directly.

____
SIGNATURE OF PARENT OR GUARDIAN DATE

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.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Initials: ________ Date: ____________

DOCTOR'S COMMENTS: ____________________

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