



135 EAST ELM AVENUE, HANOVER, PA 17331
 (717) 637-4131 1-800-333-0079
 drhalcohen@centurylink.net
 www.drhalcohen.com

WELCOME

TO OUR ORTHODONTIC PRACTICE

We would like to welcome you and your child to our office.
 Our goal is to make your 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

Today's Date: _____ Male Female
 Name: _____
LAST FIRST MI
 Nickname: _____ SS#: _____
 Child's Birth Date: ____/____/____ Child's Age: _____
 School: _____ Grade: _____
 Hobbies / Sports: _____
 Child's Home #: () _____ e-mail: _____
 Child's 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 sibling names and ages: _____
 General Dentist: _____
 Last Visit Date: _____
 Parents Marital Status: Single Widowed Separated
 Married Divorced

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

Did mom or dad have braces? Yes No
 Has your child ever been evaluated for or had orthodontic treatment before? Yes No
 List any musical instruments played: 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/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
 Please list all drugs that your child's is currently taking:

 Please list all drugs that your child is allergic to:

MOTHER'S INFORMATION

Step Mother Guardian
 Name: _____ Birth Date: ____/____/____
 Wk#: () _____ Ext: _____ Hm: () _____
 Employer: _____
 Occupation: _____
 SS#: _____ e-mail: _____

FATHER'S INFORMATION

Step Father Guardian
 Name: _____ Birth Date: ____/____/____
 Wk#: () _____ Ext: _____ Hm: () _____
 Employer: _____
 Occupation: _____
 SS#: _____ e-mail: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
 Billing Address: _____
CITY STATE ZIP
 Previous Address: _____
CITY STATE ZIP
 Hm#: _____ Wk#: _____
 Relation: _____ SS#: _____
 Employer: _____

WHO WILL BE MAKING APPOINTMENTS

Name: _____
 Wk#: () _____ Ext: _____ Hm: () _____

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

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

Please list any serious medical condition(s) that your child has had. Also list operations.

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

- | | |
|--------------------------------|----------------------------|
| Y N Clenching / Grinding Teeth | Y N Nursing Bottle Habits |
| Y N Lip Sucking / Biting | Y N Speech Problems |
| Y N Mouth Breather | Y N Thumb / Finger Sucking |
| Y N Nail Biting | Y N Tongue Thrust |

EMERGENCY CONTACT / NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: _____ Phone: _____

Address: _____

Relationship: _____

ANYTHING ELSE YOU'D LIKE US TO KNOW

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes No Don't Know

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: () _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birth Date: _____

Insured's ID# or SS#: _____

Insured's Employer: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes No Don't Know

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: () _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birth Date: _____

Insured's ID# or SS#: _____

Insured's Employer: _____

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 necessar dental services my child may need.

Signature _____ Date _____

I have been informed of the Health Insurance Portability and Accountability Act (HIPAA).

Signature of parent or guardian _____

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

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: _____ Initials: _____ Date: _____
