360.256.1755 | vpdortho@gmail.com | drlubisich.com

VANCOUVER
PEDIATRIC
DENTISTRY
& orthodontics

Tell Us About Your Child

TODAY'S DATE NICKNAME

CHILD'S NAME

BIRTHDATE AGE ❍ MALE ❍ FEMALE

SCHOOL GRADE

HOBBIES / SPORTS

CHILD'S HOME #

CHILD'S HOME ADDRESS

Who is Accompanying Your Child Today?

NAME RELATION

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? ❍ YES ❍ NO

PARENT'S MARITAL STATUS:
❍ Single ❍ Married ❍ Partnered ❍ Separated ❍ Divorced ❍ Widowed

MOTHERS INFORMATION: ❍ Stepmother ❍ Guardian

NAME BIRTHDAY

EMAIL ADDRESS

CELL # HM # EMPLOYER WK #

SS # DL #

FATHER'S INFORMATION: ❍ Stepfather ❍ Guardian

NAME BIRTHDAY

EMAIL ADDRESS

CELL # HM # EMPLOYER WK #

SS # DL #

Person Responsible For Account

NAME RELATION

BILLING ADDRESS

PREVIOUS ADDRESS

HM # CELL #

DL # SS #

EMPLOYER WK # EXT

Who Is Responsible For Making Appointments?

NAME

WK # EXT HM#

Primary Orthodontic Insurance

ORTHODONTIC COVERAGE? ❍ YES ❍ NO

INSURANCE CO. NAME INSURANCE CO. ADDRESS

INSURANCE CO. PHONE #

GROUP # (PLAN, LOCAL, OR POLICY #)

POLICY OWNER'S NAME RELATIONSHIP TO PATIENT

POLICY OWNER'S BIRTHDATE ID #

POLICY OWNER'S EMPLOYER EMPLOYER'S ADDRESS

SECONDARY ORTHODONTIC INSURANCE

ORTHODONTIC COVERAGE? ❍ YES ❍ NO

INSURANCE CO. NAME INSURANCE CO. ADDRESS

INSURANCE CO. PHONE #

GROUP # (PLAN, LOCAL, OR POLICY #)

POLICY OWNER'S NAME RELATIONSHIP TO PATIENT

POLICY OWNER'S BIRTHDATE ID #

POLICY OWNER'S EMPLOYER EMPLOYER'S ADDRESS

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

Has your child ever taken Phen-Fen? ❍ Yes ❍ No
(Also known as Redux or Pondimin)
If yes, when? ______

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 her 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? ❍ Yes ❍ No

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:
Y /N Latex Y /N Metals/Nickel Y/N Plastics

Has your child ever had any of the following medical problems?

- Y /N Abdominal Bleeding
- Y /N ADD / ADHD
- Y /N Allergies to any Drugs
- Y /N Allergic to Latex / Metals
- Y /N Allergic to Plastics
- Y /N Any Hospital Stays
- Y /N Any Operations
- Y /N Artificial Bones / Joints / Valves
- Y /N Asthma
- Y /N Cancer
- Y /N Congenital Heart Defect
- Y /N Convulsions / Epilepsy
- Y /N Diabetes
- Y /N Handicaps / Disabilities
- Y /N Hearing Impairment
- Y /N Heart Murmur
- Y /N Hemophilia
- Y /N Hepatitis
- Y /N HIV+ / AIDS
- Y /N Kidney / Liver Problems
- Y /N Lupus
- Y /N Rheumatic / Scarlet Fever
- Y /N Tuberculosis (TB)

Please discuss any medical problems that your child had: ______

Has your child ever experienced any of the following:

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

Neighbor or relative not living with you.

______
NAME PHONE

______
ADDRESS

Fine Print

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 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.

______
SIGNATURE OF PARENT OR GUARDIAN DATE

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 payment of the group insurance benefits directly to this office. i authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______
SIGNATURE OF PARENT OR GUARDIAN DATE

The Parent or Guardian who accompanies the child is responsible for payment. 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 medical / dental information above with the parent / guardian named herein. Initials: ______ Date: ______

Doctor's Comments: ______