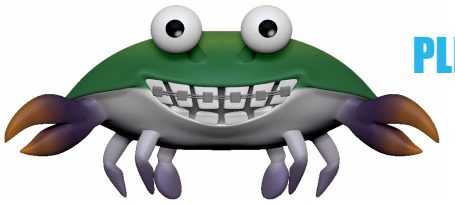
Welcome to our practice!



PLEASE FILL OUT ALL THREE PAGES

Today's Date:_____

Child's Name:_____ Nickname:_____
LAST, FIRST MI

Birthday:____/_____/_____ Age:_____ Pronouns: _____

Gender on File with Insurance: M ( ) F ( ) Other ( )

Child's Home Address: _____

Child's Home #: (_____)_____ Preferred Email:_____

School: _____ Grade: _____ Hobbies/Sports: _____

Siblings Names & Ages: _____

General Dentist _____ Date of Last Dental Visit: _____

Who may we thank for referring you? _____

Who is accompanying patient today: _____ Relation: _____

Parent/Guardian Information:

Guardian/Guarantor Name:_____Birthdate:_____

Address: (If different than above) _____

Home # _____ Cell # _____ Email _____

Employer: _____Occupation: _____Work # _____

Guardian/Guarantor Name: _____ Birthdate:_____

Address: (If different than above) _____

Home # _____ Cell # _____ Email_____

Employer: _____ Occupation: _____Work # _____

Insurance Information:

Orthodontic Coverage Yes No

Insured's Name: _____ Relation: _____ Birthdate: _____

Insurance Co.: _____Group #: _____Policy #: _____

Secondary Orthodontic Coverage Yes No

Insured's Name: _____ Relation: _____ Birthdate: _____

Insurance Co.: _____ Group #: _____ Policy #: _____

Person(s) Responsible for paying account: _____

Medical History

Is your child currently taking medications? Yes No

If so, please list here:_____

Is your child **allergic** to any medications or dental products? Yes No

If so, please list here: _____

Is your child under the care of a physician? Yes No

Physician's Name: _____ Phone _____

Is your child currently pregnant? Yes No (Please note: this question affects ability to take x-rays)

Please list any serious medical condition(s) that your child has or has ever had:

_____

_____

Have you/your child experienced any of the following:

Yes	No	Abnormal bleeding/Hemophilia	Yes	No	Convulsions
Yes	No	Heart murmur	Yes	No	Prosthetics
Yes	No	ADD/ADHD	Yes	No	Diabetes
Yes	No	Heart Surgery/Pacemaker	Yes	No	Rheumatic Fever
Yes	No	AIDS/HIV+	Yes	No	Epilepsy
Yes	No	Hemophilia	Yes	No	Scarlet Fever
Yes	No	Any hospital stay/operations	Yes	No	Frequent headaches
Yes	No	Hepatitis	Yes	No	Seizures/Fainting
Yes	No	Arthritis	Yes	No	Handicaps/Disabilities
Yes	No	Herpes/Fever blisters	Yes	No	Hay fever
Yes	No	High/Low blood pressure	Yes	No	Sickle cell disease/traits
Yes	No	Kidney problems	Yes	No	Hearing impairment
Yes	No	Cancer	Yes	No	Tuberculosis (TB)
Yes	No	Heart Problems	Yes	No	Heart attack/Stroke
Yes	No	Bone Disorders	Yes	No	Vertigo

Other (please specify):_____

Does your child have allergies to any of the following:

Yes	No	Local anesthetics	Yes	No	Latex
Yes	No	Aspirin	Yes	No	Metals
Yes	No	Ibuprofen	Yes	No	Codeine or other narcotics
Yes	No	Sulfa Drugs	Yes	No	Acrylic
Yes	No	Food (specify):	Yes	No	Animals

Other (specify):_____

Dental History

Yes	No	Has your child ever been evaluated or had orthodontic treatment before?
Yes	No	Has your child seen a general dentist in the last 6 months?
Yes	No	Have there been any injuries to the face, mouth, teeth or chin?
Yes	No	Does your child require antibiotics before dental treatment?
Yes	No	Have adenoids or tonsils been removed?
Yes	No	Has your child ever had difficulties associated with previous dental work?
Yes	No	Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?
Yes	No	Does your child brush and floss his/her teeth daily?
Yes	No	Are you aware of any "gum" problems?
Yes	No	Does your child have any of the following habits? (If so, please circle)
Yes	No	Clenching/Grinding teeth or nail biting or thumb/finger sucking
Yes	No	Lip sucking/biting or tongue thrust or mouth breather

Why have you brought your son/daughter to Dr. Koterwas today? i.e. crowding, overbite, etc...

Please Initial the Following & Sign

_____ I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's status **including insurance assignment**. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

_____ I authorize Dr. Koterwas Orthodontics to communitate with my general dentist and/or other healthcare providers involved in the treatment of my child. This includes x-rays, medical record information or any relevant documentation deemed necessary to render treatment and coordinate care for the patient.

_____ I understand that I am responsible for payment of services rendered and am also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____ I hereby authorize Dr. Koterwas Orthodontics, DDS, LLC and/or Koterwas Orthodontics of Prince Frederick to release all information necessary to secure the payment of benefits. I also assign, directly to the doctor, all insurance benefits otherwise payable to me.

Signature of Parent or Guardian Date

At Koterwas Orthodontics it is our motto that **Kindness Matters** and everyone is special, unique and has something positive to contribute to the world. Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.