Ellis Moon Orthodontics

We would like to welcome you and your child to the office of Dr. Randy Ellis and Dr. Audrey Moon. 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.

1 Tell us about Your Child

Today's Date_____

Child's Name_____
LAST FIRST MI

Nickname_____ ☐ Male ☐ Female

Child's Birthdate_____ Child's Age_____

School_____ Grade_____

Hobbies / Sports_____

Child's Home # (_____)_____

Child's Home Address_____

CITY STATE ZIP

EMAIL ADDRESS

2 Who is Accompanying Your Child Today?

Name_____

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_____

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

3 Mother's Information

☐ Step Mother ☐ Guardian

Name_____ Birthdate_____

Wk # (____)_____ Hm # (____)_____

Employer_____

How long at Current Job?_____ Job Title_____

SS #_____ DL #_____

Father's Information

☐ Step Father ☐ Guardian

Name_____ Birthdate_____

Wk # (____)_____ Hm # (____)_____

Employer_____

How long at Current Job?_____ Job Title_____

SS #_____ DL #_____

4 Person Responsible for Account

Name_____ Relation_____

Billing Address_____

CITY STATE ZIP

Birthdate_____ DL #_____

Who is responsible for making appointments?

Name_____

Wk # (____)_____ Hm # (____)_____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co. Phone #_____

Member / Subscriber ID #_____

Group # (Plan, Local or Policy #)_____

Policy Owner's Name_____

Relationship to Patient_____

Policy Owner's Birthdate_____

Policy Owner's Employer_____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co. Phone #_____

Member / Subscriber ID #_____

Group # (Plan, Local or Policy #)_____

Policy Owner's Name_____

Relationship to Patient_____

Policy Owner's Birthdate_____

Policy Owner's Employer_____

Continued on back

6 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 or tenderness in his/her jaw joint? (TMJ / TMD) ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Does your child floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician _____

Phone # (____)_____ Last visit date _____

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

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (girls) ☐ 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 that your child is allergic to

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

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

Please discuss any medical problems your child has had

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

Clenching / Grinding Teeth	Nursing Bottle Habits
Lip Sucking / Biting	Speech Problems
Mouth Breathing	Thumb / Finger Sucking
Nail Biting	Tongue Thrust

Neighbor or Relative not living with you:

Name _____

Phone (____)_____

Address _____

CITY STATE ZIP

9

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 to 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

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 _____