WELCOME
TO THE ORTHODONTIST

We would like to welcome you and your child to our office. 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.

JOSEPH E. JAMISON, DDS, P.A. *1409 MEDICAL CENTER DRIVE • WILMINGTON, NORTH CAROLINA 28401 • TEL: 763-2185*

TELL US ABOUT YOUR CHILD

Today's Date:_____

Child's Name: _____
LAST FIRST MI

Nickname:_____Sex: M F

Child's Birthdate:_____ Child's Age: _____

School:_____ Grade: _____

Hobbies/Sports: _____

Child's Home #: _____

Child's 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 w/Age: _____

_____

General Dentist:_____

Last Visit Date: _____

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

MOTHER'S INFORMATION

☐ Step Mother ☐ Guardian

Name: _____

Work #: _____ Home #:_____

Employer:_____

SS#:_____ Birthdate:_____

FATHER'S INFORMATION

☐ Step Father ☐ Guardian

Name: _____

Work #: _____ Home #:_____

Employer:_____

SS#:_____ Birthdate:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

Work #:_____ Home #: _____

Employer:_____

DL #: _____ SS #: _____

Who is Responsible for Making Appointments?

Name: _____

Work #:_____ Home #: _____

Email:_____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #:_____

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

Insured's Name:_____

Relationship to Patient: _____

Insured's Birthday: ___/___/___ & SS#: _____

Insured's Employer:_____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #:_____

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

Insured's Name:_____

Relationship to Patient: _____

Insured's Birthday: ___/___/___ & SS#: _____

Insured's Employer:_____

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 extra or missing permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain/tenderness in his 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 #: _____ 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 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:

_____

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

Y	N		Y	N	
☐	☐	Allergic to Plastic	☐	☐	Allergic to Latex/Metals
☐	☐	Heart Murmur	☐	☐	Congenital Heart Defect
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Hearing Impairment
☐	☐	HIV+/AIDS	☐	☐	Any Operations
☐	☐	Hemophilia	☐	☐	Any stays in a hospital
☐	☐	Asthma	☐	☐	Kidney/Liver problems
☐	☐	Hepatitis	☐	☐	Handicaps/Disabilities
☐	☐	Tuberculosis (TB)	☐	☐	Allergies to any drugs.

Please discuss any medical problems that your child has had:

_____

_____

_____

_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

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

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 also 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 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.

_____
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.

FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____

DOCTOR'S COMMENTS:

_____

_____

_____

_____