UCDA_AdultGenDenForm_v1:Layout 1 10/31/07 10:43 AM Page 5

University Centre
DENTAL ASSOCIATES

Child Orthodontics

301.220.1900

The benefits of a happy, healthy smile are immensurable. Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you!

About Your Child

Today's Date: _____ ❑ Male ❑ Female

Child's Name: _____
Last First MI

Nickname: _____

Birthdate: ____/ ____/ ____ Age: _____

SS# _____

Home Address: _____
Apt #

_____
City State Zip

Home Phone: ( ) _____

School: _____

Grade: _____

Person Responsible for Account: _____

Parent Information

❑ **Father** ❑ Step Father ❑ Guardian

❑ Single ❑ Married ❑ Divorced/Sep. ❑ Widow ❑ Partnered

Name: _____
Last First MI

Birthdate: ____/ ____/ ____ DL#: _____

SS#_____ Home#: _____

Work #: _____ Cell #: _____

Home Address: _____
If Different from Child's

Employer: _____

Employer Address: _____

_____
City State Zip

❑ **Mother** ❑ Step Mother ❑ Guardian

❑ Single ❑ Married ❑ Divorced/Sep. ❑ Widow ❑ Partnered

Name: _____
Last First MI

Birthdate: ____/ ____/ ____ DL#: _____

SS#_____ Home#: _____

Work #: _____ Cell #: _____

Home Address: _____
If Different from Child's

Employer: _____

Employer Address: _____

_____
City State Zip

Orthodontic Insurance

Primary Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Dental Coverage? ❑ Yes ❑ No

Insurance Company: _____

Address: _____

_____
City State Zip

Insurance Phone: ( ) _____

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

Insured's Name: _____

Birthdate: ____/ ____/ ____ Insured's ID#: _____

Insured's Employer: _____

Employer Address: _____

_____
City State Zip

Secondary Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Dental Coverage? ❑ Yes ❑ No

Insurance Company: _____

Address: _____

_____
City State Zip

Insurance Phone: ( ) _____

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

Insured's Name: _____

Birthdate: ____/ ____/ ____ Insured's ID#: _____

Insured's Employer: _____

Employer Address: _____

_____
City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

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 herby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I herby release of any information, including diagnosis and records of treatment or examination rendered to my insurance company.

_____
Signature Date

Child's Medical History

Does your child have a personal physician? ❑ Yes ❑ No

Child's Physician: _____

Phone Number: ( ) _____

Date of last visit: _____/ _____/ _____

Child's current physical health is: ❑ Good ❑ Fair ❑ Poor

Are they currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Are they taking any prescription/over the counter drugs?

❑ Yes ❑ No Please list: _____

_____

Has the child ever taken Phen-Fen? ❑ Yes ❑ No
(Also known as Redux or Pondimin)

Has puberty begun? ❑ Yes ❑ No

If female, has menstruation begun? ❑ Yes ❑ No

Are their immunizations current? ❑ Yes ❑ No

Has the child ever had any of the following diseases or medical problems:

Y N	Abdominal Bleeding/ Hemophilia	Y N	Hepatitis/Jaundice	Y N	Sulfa Drugs
Y N	AIDS or HIV Infection	Y N	Herpes/Fever Blisters	Y N	Barbiturates
Y N	Alcohol/Drug Abuse	Y N	High Blood Pressure	Y N	Sedatives
Y N	Anemia	Y N	Hospitalized for Any Reason	Y N	Iodine
Y N	Angina	Y N	Kidney Problems/Disease		
Y N	Arthritis	Y N	Liver Disease		
Y N	Artificial Bones/Joints/Valves	Y N	Low Blood Pressure		
Y N	Asthma	Y N	Leukemia		
Y N	Blood Transfusion	Y N	Lupus		
Y N	Cancer/Chemotherapy	Y N	Mitral Valve Prolapse		
Y N	Chest Pains	Y N	Pacemaker		
Y N	Colitis	Y N	Psychiatric Problems		
Y N	Congenital Heart Defect	Y N	Radiation Treatment		
Y N	Diabetes	Y N	Recent Weight Loss		
Y N	Difficulty Breathing	Y N	Respiratory Problems		
Y N	Emphysema/Easily Winded	Y N	Rheumatic/Scarlet Fever		
Y N	Epilepsy/Convulsions	Y N	Seizures		
Y N	Fainting Spells	Y N	Shingles		
Y N	Frequent Headaches	Y N	Sickle Cell Disease/Traits		
Y N	Frequently Tired	Y N	Sinus Problems		
Y N	Glaucoma	Y N	Stroke		
Y N	Hay Fever/Allergies	Y N	Swollen Ankles		
Y N	Heart Attack/Surgery	Y N	Thyroid Problems		
Y N	Heart Disease	Y N	Tuberculosis (TB)		
Y N	Heart Murmur	Y N	Ulcers/Stomach Troubles		
		Y N	Venereal Disease		

Are they allergic to any of the following:

Y N	Aspirin	Y N	Jewelry/Metals	Y N	Sulfa Drugs
Y N	Codeine	Y N	Latex	Y N	Barbiturates
Y N	Local Anesthetics	Y N	Penicillin	Y N	Sedatives
Y N	Erythromycin	Y N	Tetracycline	Y N	Iodine
		Y N	Antibiotics		

Please list any other drugs/medications that they are allergic to: _____

_____

_____

_____

_____

Dental History

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

_____

_____

Has the child ever been evaluated for or received orthodontic treatment? ❑ Yes ❑ No

Has the child ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do they now, or have they ever, experienced pain/discomfort in their jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Child's current dental health is: ❑ Good ❑ Fair ❑ Poor

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Have they ever had an injury to their:
❑ Mouth ❑ Teeth ❑ Chin

Does the child have any speech problems? ❑ Yes ❑ No
Is so please explain: _____

Do they generally breathe through their mouth? ❑ Yes ❑ No
If yes, this happens: ❑ While Awake ❑ While Asleep

Do they have any missing/extra permanent teeth? ❑ Yes ❑ No

Do they brush their teeth daily? ❑ Yes ❑ No

Do they floss their teeth daily? ❑ Yes ❑ No

Do they require antibiotics before dental treatment?
❑ Yes ❑ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. 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 the office, use the services of one or more credit reporting services.

_____

Signature *Date*

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 have verbally reviewed the medical/dental information with th patient named herein.

Initials: _____ Date: _____

Doctor's Comments _____

_____

_____

_____

_____

_____

_____

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