Orthodontics Exclusively

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Office Locations: Ft. Myers, Cape Coral & Lehigh Acres

NiceSmiles.com

DATE OF EXAM:

Child's Information

NAME (LAST, FIRST, MI) | ❑ MALE ❑ FEMALE | AGE | BIRTHDATE

SCHOOL | GRADE | HOBBIES

CHILD LIVES WITH (CHECK ALL THAT APPLY)

❑ MOTHER ❑ STEPMOTHER ❑ GRANDMOTHER ❑ GUARDIAN ❑ FATHER ❑ STEPFATHER ❑ GRANDFATHER ❑ _____

Mother's Information

NAME (LAST, FIRST, ML) | BIRTHDATE | ❑ MOTHER ❑ STEPMOTHER ❑ GRANDMOTHER | SOCIAL SECURITY NUMBER ___ ___

ADDRESS | HOME PHONE

CITY | STATE | ZIP CODE

EMPLOYER | E-MAIL | CELL PHONE | WORK PHONE

Father's Information

NAME (LAST, FIRST, MI) | BIRTHDATE | ❑ FATHER ❑ STEPFATHER ❑ GRANDFATHER | SOCIAL SECURITY NUMBER ___ ___

ADDRESS | HOME PHONE

CITY | STATE | ZIP CODE

EMPLOYER | E-MAIL | CELL PHONE | WORK PHONE

Dental History

CHILD'S DENTIST | DATE OF LAST EXAM

	YES	NO
Does child maintain 6 month dental check-ups?	❑	❑
Do child's gums bleed while brushing?	❑	❑
Does child clench or grind their teeth?	❑	❑
Has your dentist suggested an orthodontic consultation?	❑	❑
Has your child had an orthodontic consultation?	❑	❑
Has your child had any orthodontic treatment?	❑	❑

COMMENTS:

HOW DID YOU HEAR OF OUR OFFICE?

❑ DENTIST ❑ INSURANCE COMPANY ❑ NEWSPAPER ❑ PHONE BOOK
❑ TV/RADIO ❑ FRIEND _____ ❑ WEB SITE ❑ OTHER _____

NAMES OF ANYONE IN YOUR FAMILY WE HAVE SEEN

Insurance Information

DO YOU HAVE ORTHODONTIC INSURANCE?
❑ YES ❑ NO

NAME OF THE INSURANCE COMPANY

PHONE NUMBER

INSURED'S NAME

BIRTHDATE

❑ FATHER
❑ MOTHER
❑ _____

SOCIAL SECURITY NUMBER
___ ___

Financial Information

IF ORTHODONTIC TREATMENT IS NEEDED, WE OFFER A CHOICE OF PAYMENT OPTIONS FOR FEES OVER $300 (PLEASE CHOOSE ONE)

❑ PAYMENT IN FULL (MASTERCARD, VISA, CASH, MONEY ORDER, CHECK)

❑ MONTHLY PAYMENTS - INTEREST FREE INSTALLMENT PAYMENT PLAN

NAME (LAST, FIRST, MI) OF PERSON RESPONSIBLE FOR PAYMENT

❑ FATHER
❑ MOTHER
❑ _____

SOCIAL SECURITY NUMBER
___ ___

ADDRESS

HOME PHONE

CITY

STATE

ZIP CODE

EMPLOYER

HOW LONG

POSITION

WORK PHONE

Medical Information

MEDICAL DOCTOR

DATE OF LAST EXAM

IS CHILD UNDER A DOCTOR'S CARE NOW?
❑ YES ❑ NO

FOR WHAT REASON?

HAS CHILD BEEN HOSPITALIZED IN THE LAST 5 YEARS?
❑ YES ❑ NO

FOR WHAT REASON?

IS CHILD ALLERGIC TO ANY MEDICATION?
❑ YES ❑ NO

IF YES, PLEASE LIST

IS CHILD TAKING ANY MEDICATION?
❑ YES ❑ NO

IF YES, PLEASE LIST

HAS CHILD EVER HAD:	YES	NO
Anemia	❑	❑
Diabetes	❑	❑
Epilepsy	❑	❑
Hepititis or HIV/AIDS	❑	❑
Rheumatic fever	❑	❑
Heart murmur	❑	❑
Abnormal heart condition	❑	❑
Abnormal bleeding from a cut	❑	❑
Abnormal blood pressure	❑	❑

IS CHILD ALLERGIC TO:	YES	NO
Penicillin	❑	❑
Local anesthetic	❑	❑
Latex (rubber gloves)	❑	❑
Metals (ie. earrings)	❑	❑
Has patient ever taken any diet medication?	❑	❑

COMMENTS

Parent/Guardian Signature _____

Doctor's Signature _____