



**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)		<input type="checkbox"/> MALE	AGE	BIRTHDATE
		<input type="checkbox"/> FEMALE		
SCHOOL	GRADE	HOBBIES		
CHILD LIVES WITH (CHECK ALL THAT APPLY)				
<input type="checkbox"/> MOTHER <input type="checkbox"/> STEPMOTHER <input type="checkbox"/> GRANDMOTHER <input type="checkbox"/> GUARDIAN <input type="checkbox"/> FATHER <input type="checkbox"/> STEPFATHER <input type="checkbox"/> GRANDFATHER <input type="checkbox"/> _____				

Mother's Information

NAME (LAST, FIRST, MI)		BIRTHDATE	<input type="checkbox"/> MOTHER <input type="checkbox"/> STEPMOTHER <input type="checkbox"/> GRANDMOTHER	SOCIAL SECURITY NUMBER ____
ADDRESS			HOME PHONE	
CITY			STATE	ZIP CODE
E-MAIL	CELL PHONE	CELL PHONE PROVIDER		WORK PHONE

Father's Information

NAME (LAST, FIRST, MI)		BIRTHDATE	<input type="checkbox"/> FATHER <input type="checkbox"/> STEPFATHER <input type="checkbox"/> GRANDFATHER	SOCIAL SECURITY NUMBER ____
ADDRESS			HOME PHONE	
CITY			STATE	ZIP CODE
E-MAIL	CELL PHONE	CELL PHONE PROVIDER		WORK PHONE

Dental History

CHILD'S DENTIST	DATE OF LAST EXAM
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	YES	NO	COMMENTS:
Does child maintain 6 month dental check-ups?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do child's gums bleed while brushing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does child clench or grind their teeth?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has your dentist suggested an orthodontic consultation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has your child had an orthodontic consultation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has your child had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____

HOW DID YOU HEAR OF OUR OFFICE?

<input type="checkbox"/> DENTIST	<input type="checkbox"/> INSURANCE COMPANY	<input type="checkbox"/> NEWSPAPER	<input type="checkbox"/> PHONE BOOK
<input type="checkbox"/> TV/RADIO	<input type="checkbox"/> FRIEND _____	<input type="checkbox"/> WEB SITE	<input type="checkbox"/> OTHER _____

NAMES OF ANYONE IN YOUR FAMILY WE HAVE SEEN

Insurance Information

DO YOU HAVE ORTHODONTIC INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF THE INSURANCE COMPANY	PHONE NUMBER
INSURED'S NAME	BIRTHDATE	<input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> _____
EMPLOYER	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	<input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> _____	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? <input type="checkbox"/> YES <input type="checkbox"/> NO	FOR WHAT REASON?
HAS CHILD BEEN HOSPITALIZED IN THE LAST 5 YEARS? <input type="checkbox"/> YES <input type="checkbox"/> NO	FOR WHAT REASON?
IS CHILD ALLERGIC TO ANY MEDICATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST
IS CHILD TAKING ANY MEDICATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST

HAS CHILD EVER HAD:	YES	NO	IS CHILD ALLERGIC TO:	YES	NO
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber gloves)	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis or HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Metals (ie. earrings)	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever taken any diet medication?	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>			
Abnormal heart condition	<input type="checkbox"/>	<input type="checkbox"/>			
Abnormal bleeding from a cut	<input type="checkbox"/>	<input type="checkbox"/>			
Abnormal blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			

COMMENTS _____

Parent/Guardian Signature _____

Doctor's Signature _____