TYLER | DUMAS | REYES

SPECIALISTS IN ORTHODONTICS

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Please fill out this form as completely as possible prior to your child's Initial Orthodonitc Examination Appointment
(Please Print)

About Your Child

Today's Date ______________________

Child's Name ______________________ (Last / First / MI) ☐ Male ☐ Female

He/She prefers to be called ______________________ Birthdate ____/____/____ Age ______

Home Address ______________________ Apt. # ______

______________________ (City / State / Zip)

Home # ______________ Cell / Other # ______________ Email ______________

School ______________ Grade ______ Hobby/Sport ______________ How did you hear about us? ______________

List names and ages of brothers/sisters ______________________

Who is accompanying your child today? Name ______________________ Relationship ______________

Person Responsible for making appointments: Name ______________ Home # ______________ Work # ______________

Parent's Information

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Who has primary custody? ☐ Mother ☐ Father ☐ Other ______________

Mother's Name ______________________ (Last / First / MI) ☐ Mother ☐ Step Mother ☐ Guardian

Home # ______________ Cell / Other # ______________ Email ______________

Soc. Sec. # ______________ Birthdate ____/____/____ Years employed at current job ______

Employer ______________ Job Title ______________ Work # ______________ Ext ______

Father's Name ______________________ (Last / First / MI) ☐ Father ☐ Step Father ☐ Guardian

Home # ______________ Cell / Other # ______________ Email ______________

Soc. Sec. # ______________ Birthdate ____/____/____ Years employed at current job ______

Employer ______________ Job Title ______________ Work # ______________ Ext ______

Person Responsible for Account

☐ Mother ☐ Father ☐ Other ______________

Address (if different from above) ______________________

Home # ______________ Cell / Other # ______________ Email ______________

Soc. Sec. # ______________ Birthdate ____/____/____ Years employed at current job ______

Employer ______________ Job Title ______________ Work # ______________ Ext ______

Orthodontic Insurance

Primary Orthodontic Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Name of Insured ______________________ Relationship ______________

Insurance Company Name ______________________ Birthdate ____/____/____

Insurance Company Address ______________________

Group # ______________ ID # ______________ Phone # ______________

Secondary Orthodontic Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Name of Insured ______________________ Relationship ______________

Insurance Company Name ______________________ Birthdate ____/____/____

Insurance Company Address ______________________

Group # ______________ ID # ______________ Phone # ______________

Dental Care Information

Dentist's Name ____________________ Date of Last Visit ____________________

What is your primary concern about your child's teeth? ____________________

Have you had other Orthodontic consultations / treatment? ____________________ Orthodontist ____________________

Patient's attitude toward orthodontic treatment: ☐ Very motivated ☐ Will cooperate if needed ☐ Not motivated

Dental Information

Your child's current Dental health is ☐ Good ☐ Fair ☐ Poor

Your child brushes / flosses everyday? ☐ Yes ☐ No

Has your child had or noticed any of the following? (check if "Yes")

- ☐ Traumatic injury to Teeth, Mouth or Chin (Please Circle)
- ☐ Pain or tenderness around ear, joint, or side of face (TMJ / TMD)
- ☐ Teeth sensitive to hot, cold, or pressure
- ☐ Missing or extra permanent teeth
- ☐ Clenching / Grinding Teeth
- ☐ Thumb / Finger sucking - Quit what age? ________
- ☐ Nail Biting
- ☐ Pain, swelling, or bleeding of gums
- ☐ Periodontal treatment
- ☐ Speech Problems
- ☐ Breathes through mouth
- ☐ Nursing Bottle Habits
- ☐ Lip Sucking / Biting
- ☐ Tongue Thrust

Please explain any "yes" answers here ____________________

List any musical instruments played: ____________________

Medical Information

Your child's current Physical health is ☐ Good ☐ Fair ☐ Poor

Physician's Name ____________________ Date of Last Visit ____/____/____ Phone # ____________________

Is your child under a Physician's care? For what reason? ____________________

Please list all medications your child is currently taking: ____________________

Does your child require any medications prior to dental work? ____________________

Has your child had or noticed any of the following? (check if "Yes")

- ☐ Abnormal Bleeding
- ☐ ADD / ADHD
- ☐ Any Operations
- ☐ Artificial Bones / Joints / Valves
- ☐ Asthma
- ☐ Cancer / Chemotherapy
- ☐ Congenitial Heart Defect
- ☐ Diabetes
- ☐ Epliepsy / Fainting / Seizures
- ☐ Growth Disorders
- ☐ Handicaps / Disabilities
- ☐ Hearing Impairment
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis / Liver problems
- ☐ HIV+ / AIDS
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Tuberculosis (TB)

Please discuss any medical conditions / problems your child has had: ____________________

____

Has puberty begun? ☐ Yes ☐ No Female patients: Has menstrual cycle started? ☐ Yes ☐ No

Does your child have allergies to any of the following? (check if "yes")

☐ Any Medications ☐ Dental Anesthetics ☐ Latex ☐ Metals / Plastics

Please list all of your child's allergies: ____________________

Emergency Information

Name of neighbor or relative not living with you ____________________

Home # ____________________ Cell / Other # ____________________ Relationship ____________________

Address ____________________

Please bring this completed form to your child's Initial Orthodontic Exam Appointment.
We look forward to meeting you!

The information I have provided is correct to the best of my knowledge. I understand it is my responsibility to inform Tyler | Dumas | Reyes of any changes to this information.

authorize the staff of Tyler | Dumas | Reyes to look up dental and orthodontic insurance benefits for my child on my behalf and to affix my name to any and all claims or documents related to any and all benefits due me, or my dependents. I authorize payment of dental benefits for services performed with my consent otherwise payable to me, directly to Tyler | Dumas | Reyes.

Signature of parent or guardian ____________________ *Date* ____________________

Printed name of above ____________________