4320 McAuley Boulevard
Oklahoma City, OK 73120
(405) 755-8151

Matt Heim, D.D.S., M.S., P.C.

923 S. Main St.
Kingfisher, OK 73750
(405) 375-5328

1 TELL US ABOUT YOUR CHILD

Today's Date: ______________________________

Child's Full Name: __________________________

Nickname: _______________ ☐ Male ☐ Female

Child's Birthdate: ___/___/___ Age:_____

School: ________________________ Grade:_____

Child's Home #: (_____) ____________________

Child's Home Address:

____

____

Child's Hobbies: ____________________________

2 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____________ Relation:_____________

Do you have legal custody of this child? ___

Whom may we thank for referring your child?

____

Other family members seen in our office:

____

Child's Dentist: ____________________________

Last Visit Date: ____________________________

Parent's Marital Status: ____________________

3 MOTHER'S INFORMATION

☐ Mother ☐ Stepmother ☐ Guardian

Name: ________________Birthdate:__________

Wk #: ______ Ext. _____ Hm. #: ___________

Employer: ___________________________________

Job Title: ___________ SSN: _______________

FATHER'S INFORMATION

☐ Father ☐ Stepfather ☐ Guardian

Name: ________________Birthdate:__________

Wk #: ______ Ext. _____ Hm. #: ___________

Employer: ___________________________________

Job Title: ___________ SSN: _______________

4 PERSON RESPONSIBLE FOR ACCOUNT

Name: _______________ Relation: ___________

Billing Address: ____________________________

____

Wk #: ______ Ext. _____ Hm. #: ___________

Cell #: ______________ SSN: ________________

WHO IS RESPONSIBLE FOR SETTING UP APPOINTMENTS WITH US?

Name: _______________________________________

Best way to reach you? ____________________

5 PRIMARY ORTHODONTIC INSURANCE

Insurance Co. Name: ______________________

Policy Holder: ____________________________

Address: __________________________________

ID #: ______________ GR #: _______________

SECONDARY ORTHODONTIC INSURANCE

Insurance Co. Name: ______________________

Policy Holder: ____________________________

Address: __________________________________

ID #: ______________ GR #: _______________

6 WHAT IS YOUR PRIMARY REASON FOR SEEING THE ORTHODONTIST TODAY?

____

____

Our office is committed to meeting or exceeding the standards of infection control mandate by OSHA, the CDS and the ADA.

CHECK OUT OUR WEB PAGE: www.okcbraces.com

7 HAS YOUR CHILD EVER EXPERIENCED ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Bleeding/clotting disorder
Y N Problems with the gums
Y N Any hospitals stays
Y N Any surgeries: ______________
Y N Artificial bones/joints/valves
Y N Asthma
Y N Cancer: ______________
Y N Congenital heart defect
Y N Heart murmur
Y N Diabetes
Y N Drug reaction______________
Y N Missing or extra teeth
Y N Convulsions/Epilepsy
Y N Handicaps/Disabilities: ______________
Y N Hearing Impairment
Y N ADD/ADHD
Y N Hepatitis
Y N HIV+ / AIDS
Y N Kidney/Liver problems
Y N Rheumatic/Scarlet fever
Y N Sickle cell disease
Y N Tuberculosis
Y N Latex or metal allergy
Y N Trauma to mouth/teeth/jaws
Y N Temporomandibular joint dysfunction (TM)
Y N Other medical problem(s) ______________

8 DOES YOUR CHILD EXHIBIT (OR HAS EVER HAD) ANY OF THE FOLLOWING HABITS?

Y N Lip sucking or biting
Y N Teeth grinding/clenching
Y N Tongue thrusting
Y N Nail biting
Y N Thumb/Finger sucking
Y N Mouth breathing

9

Has your child ever seen or been under the care of an orthodontist? Y N
Has your child ever had a serious/difficult experience associated with previous dental work? Y N
Is your child currently under the care of physician? Y N
(If so, please give name and phone______________)

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor
Please list all drugs your child is currently taking:______________

____
Please list all drugs that your child is allergic to:______________

____

10

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 confidence, and it is my responsibility to inform this office of any changes in my child's medical status. ______________

Signature of parent or guardian Date

I authorize the dental staff to perform the necessary orthodontic services my child may need.

____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at the time of service, unless prior arrangements have been approved by our Business Manager.

OFFICE USE ONLY ... OFFICE USE ONLY ... OFFICE USE ONLY ... OFFICE USE ONLY ... OFFICE USE ONLY ... OFFICE USE ONLY ...

I verbally reviewed the medical/dental information above with the parent/guardian of this patient.

______________ ______________
Initials *Date*