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(405) 755-8151



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Kingfisher, OK 73750
(405) 375-5328

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

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 | Convulsions/Epilepsy |
| Y N | Problems with the gums | Y N | Handicaps/Disabilities: _____ |
| Y N | Any hospital stays | Y N | Hearing Impairment |
| Y N | Any surgeries: _____ | Y N | ADD/ADHD |
| Y N | Artificial bones/joints/valves | Y N | Hepatitis |
| Y N | Asthma | Y N | HIV+ / AIDS |
| Y N | Cancer: _____ | Y N | Kidney/Liver problems |
| Y N | Congenital heart defect | Y N | Rheumatic/Scarlet fever |
| Y N | Heart murmur | Y N | Sickle cell disease |
| Y N | Diabetes | Y N | Tuberculosis |
| Y N | Drug reaction _____ | Y N | Latex or metal allergy |
| Y N | Missing or extra teeth | 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 | Nail biting |
| Y N | Teeth grinding/clenching | Y N | Thumb/Finger sucking |
| Y N | Tongue thrusting | 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