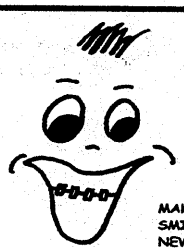
Welcome to the Orthodontics Office of

Dr. Laurie L. Fricke

a professional dental corporation

Diplomate of the American Board of Orthodontics



Thank you for coming to our office. Our goal is to make this a rewarding experience for you. We know the importance of a beautiful smile. . .because a smile is forever.

1 TELL US ABOUT YOUR CHILD

Today's Date: _____

Child's Name: _____
LAST FIRST MI

Preferred Name: _____ ❑ Male ❑ Female

Child's Home Address: _____

_____
CITY STATE ZIP

Child's Home Phone: _____

E-mail Address: _____

Birthdate: ____/____/____ Age: _____ Grade: _____

School: _____

Whom may we thank for referring you to our office?

_____

Has anyone else in your family received care from our office? ❑ YES ❑ NO

Name: _____

2 PARENT'S INFORMATION:

❑ Mother ❑ Stepmother ❑ Guardian

Name: _____

Address *(if different from patient)*: _____

_____
CITY STATE ZIP

Work # _____ Ext. _____ Home # _____

Cell Phone: _____ Beeper: _____

Employer: _____

SS#: _____

❑ Father ❑ Stepfather ❑ Guardian

Name: _____

Address *(if different from patient)*: _____

_____
CITY STATE ZIP

Work # _____ Ext. _____ Home # _____

Cell Phone: _____ Beeper: _____

Employer: _____

SS#: _____

FOR OFFICE USE ONLY

New Patient Appointment: _____

Diagnostic Records Appointment: _____

Consultation: _____

3 DENTAL INSURANCE

Orthodontic Coverage: ❑ *YES* ❑ *NO*

PRIMARY INSURANCE:

Ins. Co. Name: _____

Ins. Co. Phone: _____

Insured's Name: _____

Insured's Birthdate: _____

Relationship to Patient: _____

Insured's SS#: _____

Insured's Employer: _____

Who will be bringing patient?

Name: _____

Phone # _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relationship: _____

Work # _____ Home # _____

4 PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relation: _____ SS#: _____

Billing Address: _____

_____
CITY STATE ZIP

Work # _____ Ext. _____ Home # _____

Cell Phone: _____ Beeper: _____

Employer: _____

If you desire a payment plan, please sign below to allow us to verify your credit.

_____
SIGNATURE DATE

CONTINUED ON REVERSE . . .

5 DENTAL HISTORY

Patient's Name: _____

General Dentist: _____

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

_____

Has you child ever had orthodontic treatment? ..... ❑ No ❑ Yes

Has there been any injury to the face, mouth, teeth or chin? ..... ❑ No ❑ Yes

List any musical (wind) instruments played: _____

_____

Have adenoids or tonsils been removed? ..... ❑ No ❑ Yes

Has you child been informed of any missing or extra permanent teeth? ..... ❑ No ❑ Yes

Has you child ever had any pain/tenderness in his jaw joint (TMJ / TMD)? ..... ❑ No ❑ Yes

Has you child experienced any of the following:

- ❑ No ❑ Yes Muscular soreness around head and neck?
- ❑ No ❑ Yes Headaches (more than normal)?
- ❑ No ❑ Yes Jaw joint clicking or popping?
- ❑ No ❑ Yes Jaw joint soreness?
- ❑ No ❑ Yes Ringing in the ears?

Child's Physician: _____

Is your child currently under the care of a physician for a medical condition? ..... ❑ No ❑ Yes

Please describe your child's current physical health:
❑ Good ❑ Fair ❑ Poor

Please list all drugs that your child is allergic to: _____

_____

_____

Does your child brush his/her teeth daily? ..... ❑ No ❑ Yes

Does your child floss his/her teeth daily? ..... ❑ No ❑ Yes

6 HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- ❑ No ❑ Yes Blood Disease?
- ❑ No ❑ Yes Hemophilia?
- ❑ No ❑ Yes Hepatitis?
- ❑ No ❑ Yes Immunosuppressed?
- ❑ No ❑ Yes Jaundice?
- ❑ No ❑ Yes Rheumatic Fever?
- ❑ No ❑ Yes Heart Disease?
- ❑ No ❑ Yes Tuberculosis
- ❑ No ❑ Yes Diabetes?
- ❑ No ❑ Yes Endocrine Problems?
- ❑ No ❑ Yes Bone Disorders?
- ❑ No ❑ Yes Epilepsy?
- ❑ No ❑ Yes Allergic to Latex / Metals?
- ❑ No ❑ Yes Handicaps / Disabilities?
- ❑ No ❑ Yes Asthma?

Please discuss any medical problems that your child has had:

_____

_____

_____

_____

_____

_____

7 HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING?

❑ No	❑ Yes	Thumb/Finger Sucking?	❑ No	❑ Yes	Mouth Breather?
❑ No	❑ Yes	Have they stopped?	❑ No	❑ Yes	Speech Problems?
❑ No	❑ Yes	Lip Sucking/Biting?	❑ No	❑ Yes	Nail Biting?
❑ No	❑ Yes	Clenching/Grinding Teeth?	❑ No	❑ Yes	Tongue Thrust

THANK YOU!

Please read the above information and sign below.

Signature _____ Date _____

Additional Comments: _____

_____

_____

_____

_____