

# Lucas Orthodontic Group

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## CHILD WELCOME FORM

HIPAA Privacy Review, Initial & Date  
 \_\_\_\_\_

Today's date:					
<b>CHILD INFORMATION</b>					
Child's last name:		First:		Middle:	
Nickname:					
Birth date:     /     /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Email:	
Home address:				Home #:	
City:		State:		ZIP:	SSN #:
School:		Grade:	Hobbies/Sports:		
<b>GENERAL INFORMATION</b>					
Whom may we thank for referring you?					
General Dentist:			Last Visit Date:		
Dentist Phone #:					
Other Siblings:					
<b>PARENT'S INFORMATION</b>					
Who is responsible for the account:		Parent's Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
<input type="checkbox"/> Father <input type="checkbox"/> Step Father <input type="checkbox"/> Guardian		<input type="checkbox"/> Mother <input type="checkbox"/> Step Mother <input type="checkbox"/> Guardian			
Name:		Birth date:     /     /		Name:	
Address:		Address:			
City:	State:	ZIP:	City:	State:	ZIP:
SSN:		DL #:		SSN:	
Work #:		Home #:		Work #:	
Cell #:		Email:		Cell #:	
Employer:		Occupation:		Employer:	
Employer's Address:			Employer's Address:		
City:	State:	ZIP:	City:	State:	ZIP:
<i>If you have Orthodontic Insurance Coverage for the Child, please fill out below:</i>					
Insurance Company Name:			Insurance Company Name:		
Insurance Address:			Insurance Address:		
City:	State:	ZIP:	City:	State:	ZIP:
Insurance Phone #:			Insurance Phone #:		
Group #:		ID #:		Group #:	
<b>AUTHORIZATION</b>					
<p>This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting agencies. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance company does not cover. I authorize the dentist to release all information necessary to secure the payment of benefits. I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.</p>					
Signature of Parent or Guardian:				Date:	

## MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Child's Physician's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Your child's current physical health is:  Good  Fair  Poor

Is your child currently under the care of a physician?  Yes  No  
Please explain: \_\_\_\_\_

Are your child's immunizations current?  Yes  No

Is your child currently taking any prescription/over-the-counter drugs?  Yes  No

Please list each one: \_\_\_\_\_

Have you ever taken Phen-Fen? Also known as Redux or Pondimin.  Yes  No  
If so, when? \_\_\_\_\_

### Has your child ever had any of the following diseases or medical problems:

Y N Abnormal bleeding/Hemophilia	Y N Hearing Impairment
Y N ADD/ADHD	Y N Heart Murmur
Y N AIDS	Y N Hemophilia
Y N Any hospital stays/Operations	Y N Hepatitis
Y N Artificial bones/Joints/Valves	Y N Kidney Problems
Y N Asthma	Y N Liver Problems
Y N Cancer/Chemotherapy	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Prosthetics
Y N Convulsions	Y N Rheumatic Fever
Y N Diabetes	Y N Scarlet Fever
Y N Epilepsy	Y N Sickle Cell Disease/Traits
Y N Handicaps/Disabilities	Y N Tuberculosis (TB)

List any serious medical condition(s) that your child has ever had:  
\_\_\_\_\_  
\_\_\_\_\_

### Is your child allergic to any of the following?

Y N Latex                      Y N Nickel/Metals                      Y N Plastic

List any other drugs/materials that your child is allergic to: \_\_\_\_\_  
\_\_\_\_\_

## DENTAL HISTORY

What are the main orthodontic concerns you would like to accomplish?  
\_\_\_\_\_

Has your child ever been evaluated for orthodontic treatment?  Yes  No

Has your child ever had a serious/difficult problem associated with any previous dental work?  Yes  No

Has your child ever experienced pain or discomfort in their jaw joint (TMJ/TMD)?  Yes  No

Your child's current dental health is:  Good  Fair  Poor

Has your child ever had injury to your (circle one):                      Mouth      Teeth      Chin

Does your child have any speech problems?  Yes  No

Does your child generally breathe through their mouth?  Yes  No

If yes, please circle:      While Awake      While Asleep

Does your child have any missing or extra permanent teeth?  Yes  No

Does your child require antibiotics before dental treatment?  Yes  No

Does your child brush their teeth daily?  Yes  No

Does your child floss their teeth daily?  Yes  No

Does /did your child have any of the following habits?

Y N Clenching/Grinding Teeth	Y N Lip Sucking/Biting
Y N Nail Biting	Y N Thumb/Finger Sucker
Y N Tongue Thrust	Y N Used Pacifier

## RELEASE OF MEDICAL RECORDS

I authorize Lucas Orthodontic Group to release x-rays and photographs on file regarding my medical treatment to the person(s) listed below. I understand that by signing this release that the designated person(s) will be able to speak with any staff member of Lucas Orthodontic Group regarding my protected healthcare information.

Furthermore, I understand that Lucas Orthodontic Group cannot be held liable for any information the below stated person(s) may obtain regarding my medical care.

I understand that revocation of this authorization must be provided to Lucas Orthodontic Group in writing.

Lucas Orthodontic Group may release x-rays and photographs to the following specified person(s) other than myself:

To my Dentist, \_\_\_\_\_

To my Periodontist, \_\_\_\_\_

To my Oral Surgeon, \_\_\_\_\_

Signature

Date

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic service my child may need.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have verbally reviewed the medical/dental information above with parent/guardian and patient named herein.

Signature of Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE USE ONLY**