WERMERSON ORTHODONTICS

WELCOME, were glad you're here!

Please Tell Us About Your Child

Today's Date: _____

Child's Name: (LAST, FIRST, MI) _____ Nickname: _____

Birthdate: ____/____/____ Age: _____ ☐ Male ☐ Female School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: _____ **Child's Home Address:** _____

APT/CONDO #

CITY STATE ZIP

Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? _____

List brothers / sisters with age: _____

General Dentist: _____ Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Mother's Information

☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ____/____/____

Wk #: _____ Ext. _____ Hm #: _____

Cell #: _____

Employer: _____

How long at current job: _____ Job title: _____

SS #: _____ E-Mail: _____

Father's Information

☐ Step Father ☐ Guardian

Name: _____ Birthdate: ____/____/____

Wk #: _____ Ext. _____ Hm #: _____

Cell #: _____

Employer: _____

How long at current job: _____ Job title: _____

SS #: _____ E-Mail: _____

Person Responsible for Account

Name: _____ Relation: _____

Billing Address: (CITY, STATE, ZIP) _____

Previous Address: (CITY, STATE, ZIP) _____

Hm #: _____ Cell #: _____ Employer: _____

Wk #: _____ Ext. _____ SS #: _____

E-Mail: _____

Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ ID #: _____

Policy Owner's Employer: _____ Employer's Address: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ ID #: _____

Policy Owner's Employer: _____ Employer's Address: _____

CONTINUED ON BACK

6801 South Minnesota Avenue, Sioux Falls, SD 57108
7109 West 26th Street, Sioux Falls, SD 57106
1515 West Holly Boulevard, Brandon, SD 57005

Phone: (605) 274-0555
WermersonOrthodontics.com

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

_____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played: _____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

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

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician? _____ Phone #: _____ Date of Last Visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) If so, what date? (_____m_____y) ☐ Yes ☐ No

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

Please list all drugs that your child is currently taking: _____

Has your child taken or presently taking medications for ADD/ADHD? ☐ Yes ☐ No

Please list all drugs / things your child is allergic to: _____

Is your child allergic to:

Y N Latex Y N Metals/Nickel Y N Plastics

Has your child ever had any of the following medical problems ?

Y	N	Abnormal Bleeding	Y	N	Asthma	Y	N	Hemophilia
Y	N	ADD/ADHD	Y	N	Cancer	Y	N	Hepatitis
Y	N	Allergies to any Drugs	Y	N	Congenital Heart Defect	Y	N	HIV+ / AIDS
Y	N	Allergic to Latex / Metals	Y	N	Convulsions / Epilepsy	Y	N	Kidney / Liver Problems
Y	N	Allergic to Plastics	Y	N	Diabetes	Y	N	Lupus
Y	N	Any Hospital Stays	Y	N	Handicaps / Disabilities	Y	N	Rheumatic / Scarlet Fever
Y	N	Any Operations	Y	N	Hearing Impairment	Y	N	Tuberculosis (TB)
Y	N	Artificial Bones / Joints / Valves	Y	N	Heart Murmur			

Please discuss any medical problems that your child has had: _____

_____

Does your child require antibiotics before any dental care? ☐ Yes ☐ No

Has your child ever experienced any of the following ?

Y	N	Clenching / Grinding Teeth	Y	N	Nail Biting	Y	N	Thumb / Finger Sucking = ongoing Y N
Y	N	Lip Sucking / Biting	Y	N	Nursing Bottle Habits			or Stopped at age? _____
Y	N	Mouth Breather	Y	N	Speech Problems	Y	N	Tongue Thrust

Neighbor or Relative not living with you.

Name: _____ Phone #: _____

Address: (CITY, STATE, ZIP) _____

The Parent or Guardian who accompanies the child is responsible for payment.

Our Office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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 of confidence and 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 services my child may need.

Signature of parent or guardian _____ **Date** _____

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 and patient named herein.

Initials: _____ **Date:** _____ **Doctor's Comments:** _____

_____

WERMERSON ORTHODONTICS

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____ have received a copy of Wermerson Orthodontics
(Parent/Guardian print name) Notice of Privacy Practices.

_____

(Please print Patient Name)

_____

(Patient/Parent/Guardian signature)

_____

(Date)

_____

_____

For Wermerson Orthodontics office use, in the event the Notice of Privacy Practices isn't signed. We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining the acknowledgement
- ○ Other (Please specify)

_____

_____