michael teichman

mto

orthodontics

We would like to welcome you and your child to our office. Our goal is to make every visit pleasant and educational. Our desire is for your child to have a healthy and beautiful smile that lasts a lifetime.

Child's Name: _____ Birthdate: _____ ☐ Male ☐ Female
First MI Last Preferred Nickname?

Address: _____ Telephone: (____) _____
Street / City / ZIP

Please list name(s) of other family members who have seen Dr. Teichman: _____

Person(s) responsible for account: Name(s): _____

Address *(if different than child's)*: _____

What is your or your dentist's primary concern? _____

Whom can we thank for referring you? _____

FATHER'S INFORMATION

Name: _____ ☐ Father ☐ Stepfather ☐ Other _____ ☐ Married ☐ Divorced ☐ Single

Address *(if different than child's)*: _____ Telephone: (____) _____
Street / City / ZIP

Employer: _____ Telephone: (____) _____
Business Name Union Name Local #

Dental Insurance Co.: _____ Group #: _____

Address: _____ Telephone: (____) _____
Street / City / State / ZIP

Social Security No.: _____ Birthdate: _____

MOTHER'S INFORMATION

Name: _____ ☐ Mother ☐ Stepmother ☐ Other _____ ☐ Married ☐ Divorced ☐ Single

Address *(if different than child's)*: _____ Telephone: (____) _____
Street / City / ZIP

Employer: _____ Telephone: (____) _____
Business Name Union Name Local #

Dental Insurance Co.: _____ Group #: _____

Address: _____ Telephone: (____) _____
Street / City / State / ZIP

Social Security No.: _____ Birthdate: _____

FOR BILLING PURPOSES:
I hereby authorize Dr. Teichman to use my signature on file for insurance billing purposes, and futher authorize payment of insurance benefits, otherwise payable to me, directly to him. Where appropriate, credit reports may be obtained.

Signed _____
Patient (or Parent if Patient is a Minor)

OTHER DENTAL INSURANCE

Name of Insured: _____ Employer: _____

Address: _____ Dental Insurance Co.: _____

SS #: _____ Birthdate: _____ Address: _____

Relationship to Child: _____ Tel. No. (____) _____ Group #: _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. 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 services.

Signature _____ **Date** _____

— PLEASE COMPLETE REVERSE SIDE —

1. Is your child currently under medical treatment? Describe: _____ ☐ Yes ☐ No
2. Is your child currently taking any medication? List: _____ ☐ Yes ☐ No
3. Who is your child's physician? Name & Phone: _____
4. Does your child have a history of any of the following:

Allergies: ☐ Plastic ☐ Metals ☐ Latex ☐ Aspirin ☐ Codeine ☐ Dental Anesthetics ☐ Erythromycin ☐ Penicillin ☐ Tetracycline List any others: _____

Heart Trouble / Defects / Murmur / Attack / Surgery Describe: _____

Artificial Bones / Joints / Valves Describe: _____

Physical and/or Mental Limitations Describe: _____

Abnormal Bleeding	☐ Yes ☐ No	Gag Reflex	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
ADD/ADHD	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Phobias	☐ Yes ☐ No
Alcohol Abuse	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Pregnant	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hearing Difficulties	☐ Yes ☐ No	Psychiatric Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Rheumatic/Scarlet Fever	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Herpes/Fever Blisters	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Cancer/Chemo	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Colitis	☐ Yes ☐ No	High Fevers	☐ Yes ☐ No	Sickle Cell Anemia	☐ Yes ☐ No
Delayed Development	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Hospitalization (any)	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Difficulty Breathing	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	TMD/TMJ/Clicking	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No
Fainting Spells	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Frequent Headaches	☐ Yes ☐ No	Motion Sickness	☐ Yes ☐ No		

5. Last dental visit was (date) _____ with Dr. _____ (phone) _____
6. Have there been any unfavorable dental experiences? Describe: _____ ☐ Yes ☐ No
7. Does your child have any of the following habits? If not presently, at what age did habit stop? _____

Thumb/Finger Sucking	☐ Yes ☐ No	Lip Sucking	☐ Yes ☐ No	Grinding/Clenching	☐ Yes ☐ No
Tongue Thrust	☐ Yes ☐ No	Nail Biting	☐ Yes ☐ No	Mouth Breathing	☐ Yes ☐ No

Explanation of question(s) answered Yes: _____

_____

_____

8. Have there been any injuries to teeth? Describe: _____ ☐ Yes ☐ No
9. Family dental history:
   Has the patient had a previous orthodontic consultation or treatment? Date _____ ☐ Yes ☐ No
   Does an adult assist with brushing? ☐ Yes ☐ No Does an adult assist with flossing? ☐ Yes ☐ No
   Has either parent been treated orthodontically? ☐ Yes ☐ No
10. Where does your child attend school? _____
11. Sports and/or hobbies that your child is involved in? _____

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, BEING THE PARENT, GUARDIAN, CUSTODIAN OF THE ABOVE MINOR, DO HEREBY AUTHORIZE SUCH DENTAL CARE THE JUDGMENT OF THE DENTIST MAY DICTATE.

Signature _____ Date _____ Reviewed By _____

• ***FOR OFFICE USE ONLY*** • ***MEDICAL HISTORY UPDATE*** • ***FOR OFFICE USE ONLY*** • ***MEDICAL HISTORY UPDATE*** •

Date _____ Changes _____ Initials _____

Date _____ Changes _____ Initials _____

Date _____ Changes _____ Initials _____