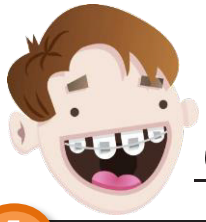

WELCOME TO THE ORTHODONTIC PRACTICE OF

Dr. Hani Thariani

1 TELL US ABOUT YOUR CHILD

TODAY'S DATE: _____

CHILD'S NAME: _____
LAST FIRST MI

PREFERS TO BE CALLED: _____

☐ M ☐ F BIRTHDATE: _____/_____/_____ AGE: _____

SCHOOL: _____ GRADE: _____

HOME ADDRESS: _____

_____
CITY STATE ZIP

HOME #: _____

HOBBIES/SPORTS: _____

GENERAL DENTIST: _____

DATE OF LAST VISIT: _____

EMAIL ADDRESS: _____

2 PARENTAL INFORMATION

☐ **MOTHER** ☐ STEPMOTHER ☐ GUARDIAN

NAME: _____ BIRTHDATE: _____/_____/_____

WORK #: _____ HOME #: _____

EMPLOYER: _____

LENGTH AT CURRENT JOB: _____ JOB TITLE: _____

☐ **FATHER** ☐ STEPFATHER ☐ GUARDIAN

NAME: _____ BIRTHDATE: _____/_____/_____

WK#: _____ HM#: _____

EMPLOYER: _____

LENGTH AT CURRENT JOB: _____ JOB TITLE: _____

3 PRIMARY DENTAL INSURANCE

ORTHODONTIC COVERAGE? YES ☐ NO ☐ I DON'T KNOW ☐

INSURANCE COMPANY: _____

DENTAL CLAIM'S ADDRESS: _____

_____

POLICYHOLDER'S NAME: _____

POLICYHOLDER'S BIRTHDATE: ___/___/___ ID #: _____

IF ID# IS UNKNOWN, PLEASE PROVIDE POLICYHOLDER'S SS#

POLICYHOLDER'S SS#: _____

GROUP #: _____

EMPLOYER: _____

RELATIONSHIP TO PATIENT: _____

POLICYHOLDER'S HOME ADDRESS (IF DIFFERENT FROM CHILD'S):

_____

_____

4 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 OTHER FAMILY MEMBERS SEEN BY US: _____

_____

PARENT'S MARITAL STATUS: ☐ SINGLE ☐ PARTNERED ☐ DIVORCED ☐ MARRIED ☐ SEPARATED ☐ WIDOWED

5 HEALTH HISTORY

WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH?

_____

Y N HAS YOUR CHILD EVER BEEN EVALUATED FOR ORTHODONTIC TREATMENT BEFORE?
IF YES, AND TREATMENT WAS RECOMMENDED, WAS TREATMENT STARTED? **Y N**
PLEASE ELABORATE: _____

_____

Y N HAS YOUR CHILD BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH?

LIST MUSICAL INSTRUMENTS PLAYED: _____

HAS YOUR CHILD EVER EXPERIENCED ANY OF THE FOLLOWING?

Y N	CLENCHING / GRINDING TEETH	**Y N**	NURSING/BOTTLE HABITS
Y N	LIP SUCKING / BITING	**Y N**	SPEECH PROBLEMS
Y N	MOUTH BREATHER	**Y N**	THUMB / FINGER SUCKING
Y N	TONGUE THRUST	**Y N**	NAIL BITING

Y N INJURIES TO THE FACE, MOUTH, TEETH OR CHIN

Y N PAIN / TENDERNESS IN THE JAW JOINT (TMJ/TMD)

Y N TONSILS / ADENOIDS REMOVED

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

Y N LATEX **Y N** METALS/NICKEL **Y N** PLASTICS

PLEASE DISCUSS ANY MEDICAL PROBLEMS THAT YOU WOULD LIKE OUR OFFICE TO BE AWARE OF: _____

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD TO THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS. I ALSO AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES THAT MY CHILD MAY NEED.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AND THAT I AM RESPONSIBLE FOR ANY PAYMENTS AND DEDUCTIBLES THAT MY INSURANCE DOES NOT COVER. I HEREBY AUTHORIZE PAYMENT OF THE GROUP INSURANCE BENEFITS (IF ANY) DIRECTLY TO THIS OFFICE.

_____
SIGNATURE OF PARENT OR GUARDIAN DATE

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