

WELCOME TO DR. WELMERINK'S OFFICE

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Today's Date: _____ Patient's E-Mail Address: _____

Child's Name: _____ Nickname: _____

Male Female Last Child's Birthdate: ____/____/____ First MI Child's Age: ____ Hm # _____

Child's Home Address: _____ City State Zip

School: _____ Grade _____

Who is accompanying your child today? _____ Relationship

Do you have legal custody of this child? Yes No

Whom may we Thank for referring you? Please check all that apply. Dentist / Hygienist Mail flyer Yellow pages
 Internet (search engine) Our Website Saw sign Magazine ad Other _____
 Patient (please specify all if more than one) _____

List brothers/sisters with age: _____

General Dentist: _____ Last visit date: _____

Parent's Marital Status: Single Married Divorced Widowed Separated

Mother's Information: Stepmother Guardian Hm # _____ Cell# _____

Name: _____ SS#: _____ Birthday: ____/____/____

Home Address: (if different) _____ City State Zip

Employer: _____ Wk # _____ Ext. _____

Employer's Address _____

Job Title: _____ How long at current job: _____

E-Mail _____ Which is the best way to contact you? Home Work E-Mail Cell

Father's Information: Stepfather Guardian Hm # _____ Cell# _____

Name: _____ SS#: _____ Birthday: ____/____/____

Home Address: (if different) _____ City State Zip

Employer: _____ Wk # _____ Ext. _____

Employer's Address _____

Job Title: _____ How long at current job: _____

E-Mail _____ Which is the best way to contact you? Home Work E-Mail Cell

Person Responsible for Account: _____ Relationship

Billing Address: _____ City State Zip

Employer: _____ Wk # _____ Ext. _____ Hm# _____

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)? Yes No

Please describe your child's current physical health: Good Fair Poor **(CONTINUED ON BACK)**

Neighbor or relative for emergency contact: _____

Name _____ Relationship _____
Address: _____ Phone #: _____
City State Zip

Primary Orthodontic Insurance:

Orthodontic Coverage? Yes No Insurance Co. Name: _____

Insurance Co. Address: _____
City State Zip

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

Policy Owner's Name: _____ Birthdate: ____/____/____
Relationship _____

Policy Owner's Employer: _____ SS#: _____

Secondary Orthodontic Insurance:

Orthodontic Coverage? Yes No Insurance Co. Name: _____

Insurance Co. Address: _____
City State Zip

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

Policy Owner's Name: _____ Birthdate: ____/____/____
Relationship _____

Policy Owner's Employer: _____ SS#: _____

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

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

If yes, where: _____

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

Have adenoids and/or tonsils been removed? Yes No

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

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

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

- | | | |
|-----------------------------------|------------------------------|-------------------------------|
| Y N Abnormal Bleeding | Y N Congenital Heart Defect | Y N Lip sucking / biting |
| Y N ADD / ADHD | Y N Convulsions / Epilepsy | Y N Mouth Breather |
| Y N Allergic to any Drugs | Y N Diabetes | Y N Nail Biting |
| Y N Allergic to Latex / Metals | Y N Handicaps / Disabilities | Y N Rheumatic / Scarlet Fever |
| Y N Any Hospital Stays/Operations | Y N Heart Murmur | Y N Speech Problems |
| Y N Asthma | Y N Hepatitis | Y N Thumb / Finger Sucking |
| Y N Cancer | Y N HIV+ / AIDS | Y N Tongue Thrust |
| Y N Clenching / Grinding Teeth | Y N Kidney / Liver problems | Y N Tuberculosis (TB) |

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

Please list all drugs your child is allergic to: _____

Please list all drugs your child is currently taking: _____

I understand that the information 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.

Signature

Date

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