smiles by dr. jung | braces for adults & children

Welcome (Child)

to the office of

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Specialist in Orthodontics

Member American Association of Orthodontists

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About Your Child

Please circle ☐M / F☐ Today's Date:_____

Name Preferred to be Called :_____
Last First MI

Child's Name:_____

Child's Birthdate:_____/_____/_____ Child's Age:_____

Child's Home Phone #:_____

Child's Home Address:_____

_____Zip_____

Child's School_____

General Dentist: (name, address, phone) _____

_____

_____

Other Family Members Seen By Us:_____

_____

Whom may we **Thank** for referring you?(name, address, phone)

_____

Parents

Father's Information: ☐ Step Father

Name:_____

Home #:_____

Cell #:_____

Work #:_____Ext._____

Home Address:_____

Email:_____

CDL #_____SS #_____

Employer:_____

Mother's Information: ☐ Step Mother

Name:_____

Home #:_____

Cell #:_____

Work #:_____Ext._____

Home Address:_____

Email:_____

CDL #_____SS #_____

Employer:_____

Responsible Party: ☐ Both Parents ☐ Mother ☐ Father

Orthodontic Insurance

Orthodontic Coverage: ☐ No ☐ Yes **PRIMARY**

Insurance Co. Name:_____

Insurance Co. Email:_____

Insurance Co. Phone #:_____

Insurance Co. Address:_____

_____

Group Name or Group # (Plan, Local, or Policy #):

_____

Insured's Name:_____Relation:_____

Insured's Birthday:____/____/____S.S. #:____-____-_____

Insured's Employer:_____

FOR OFFICE USE ONLY

Insurance Benefits:_____

Orthodontic Coverage: ☐ No ☐ Yes **SECONDARY**

Insurance Co. Name:_____

Insurance Co. Email:_____

Insurance Co. Phone #:_____

Insurance Co. Address:_____

_____

Group Name or Group # (Plan, Local, or Policy #):

_____

Insured's Name:_____Relation:_____

Insured's Birthday:____/____/____S.S. #:____-____-_____

Insured's Employer:_____

FOR OFFICE USE ONLY

Insurance Benefits:_____

Medical History

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

Y	N		Y	N	
☐	☐	Heart Murmur	☐	☐	Congenital Heart Defect
☐	☐	Cancer	☐	☐	Convulsions / Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Hearing Impairment
☐	☐	HIV+ / AIDS	☐	☐	Any Operations
☐	☐	Hemophilia	☐	☐	Hospitalized for Any Reason
☐	☐	Asthma	☐	☐	Kidney / Liver Problems
☐	☐	Hepatitis	☐	☐	Handicaps / Disabilities
☐	☐	Tuberculosis (TB)	☐	☐	Allergies to any Drugs
☐	☐	Allergic to Plastic	☐	☐	Allergic to Latex / Metals

Does your child have any of the following habits?

Y	N		Y	N	
☐	☐	Thumb / Finger Sucking	☐	☐	Mouth Breather
☐	☐	Lip Sucking / Biting	☐	☐	Speech Problems
☐	☐	Clenching / Grinding Teeth	☐	☐	Nail Biting
☐	☐	Nursing Bottle Habits	☐	☐	Tongue Thrust

Dental Concerns

What is the main thing you would like to find out by coming to see Dr. Jung and what would you like to see done to your smile?

_____

_____

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

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

List any musical instruments played:_____

_____

Have adenoids or tonsils been removed? ☐ No ☐ Yes

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

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

How many times does your child brush his/her teeth daily?_____

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

Child's Physician:_____

Phone #:_____

Date of Last Visit:_____

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

Has puberty begun? ☐ No ☐ Yes

Has menstruation begun? (girls) ☐ No ☐ Yes

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

Please list all drugs that your child is currently taking:

_____

Please list all drugs that your child is allergic to:

_____

Thank You

for filling out this form completely

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 this office, use the services of one or more credit reporting services.

_____

Signature of parent or guardian Date

Dr.'s Notes

Date:

PHI ❒ PHII ❒ Full ❒ LTX ❒

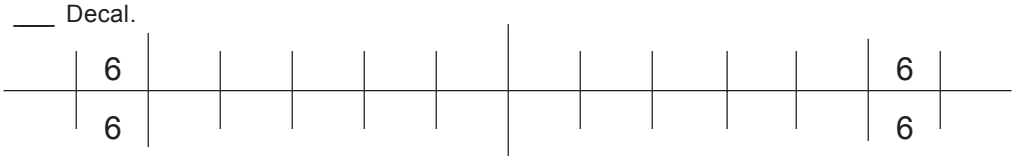
Fee $:

For Office Use Only

Date_____

Name_____Age_____

___ Chipped ___ Erupting
___ Caries ___ Space Loss
___ Discol. ___ Impactions
___ Decal.



Max.	Anteriors	Mand.
_____	Acceptable	_____
_____	Irregular	_____
_____	Crowding	_____
_____	Spacing	_____
_____	Protrusive	_____
_____	Upright	_____
_____	Rerusive	_____
_____	MIdline	_____
_____	Open	_____
_____	Closed	_____

_____

Disp.:_____

_____

Request PAX_____

Overbite_____mm

Overjet_____mm

Spee Curve_____

Crossbite_____

Profile_____

Chin_____

Nose_____

Lips_____

Hygiene_____

Ging. Cond._____

Vest._____

Peri. Musc._____

Tongue_____

Frenums_____

Speech_____

TMJ_____

Resp._____

Habits_____

Note:_____

_____

_____

_____

Classification

Canine	Molar
	I
	II - 1
	II - 2
	III

Recall_____

_____

Construction_____

_____