Jones Orthodontics

STANDARD MEDICAL INFORMATION FORM

ABOUT YOUR CHILD

Date ____________________

Name (Last, First, MI) ____________________

Nickname ____________________

Birthdate ________ Age ______ Male ☐ Female ☐

School ________ Grade ______

Hobbies/Sports/Activities ____________________

Address ____________________

City ________ State ______ Zip ______

Phone (______) ____________________

Lives with ____________________

E-Mail ____________________

Who is accompanying your child today? ____________________

Relationship ________ Legal custody YES ☐ NO ☐

Whom May We Thank for Referring You ____________________

Other Family Members Seen Here ____________________

General Dentist ____________________

Last Visit Date ____________________

Parent/Guardian Name (Last, First, MI) ____________________

Address ____________________

City ________ State ______ Zip ______

Primary Phone (______) ____________________

Other Phone (______) ____________________

Marital Status ____________________

Spouse/Partner Name ____________________

Primary Contact Person ____________________

Primary Contact Phone (______) ____________________

RESPONSIBLE PARTY INFORMATION

Name (Last, First, MI) ____________________

Address same as above ☐ ____________________

City ________ State ______ Zip ______

How long at this address ______

Primary Phone (______) ____________________

Other Phone (______) ____________________

Birthdate ________ Employer ________

ORTHODONTIC INSURANCE

Orthodontic Coverage YES ☐ NO ☐

Insured's Name ____________________

Insured's SSN ____________________

Insurance Company ____________________

Group Number ____________________

Local Number ____________________

Insurance Co. Address ____________________

City ________ State ______ Zip ______

Phone of Insurance (______) ____________________

Richard T. Jones DDS, PS | Diplomate, American Board of Orthodontics

jonesorthodontics.com | p. (206) 542-6188 | f. (206) 546-0293

18550 Firlands Way North | Shoreline, WA 98133

Do you have dual coverage YES ☐ NO ☐

Insured's Name ______

Insured's SSN ______

Insurance Company ______

Group Number ______

Local Number ______

Insurance Co. Address ______

City ______ State ______ Zip ______

Phone of Insurance (______) ______

Insured's Employer ______

MEDICAL HISTORY

Is your child currently under the care of a physician? If yes, please explain.

______

______

Is your child taking any prescription, over-the-counter or herbal medication?

YES ☐ NO ☐

Please list each medication ______

______

Has menstruation begun? (female) YES ☐ NO ☐

PLEASE CIRCLE IF YOUR CHILD HAS OR HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N Abnormal Bleeding
Y N ADD/ADHD
Y N Anemia
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Arthritis/Rheumatism
Y N Canker or cold sores
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Disabilities
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Eating Disorders
Y N Epilepsy/Seizures
Y N Hearing Impairment
Y N Heart Disease/Surgery
Y N Hepatitis Type ______
Y N Herpes
Y N HIV/AIDS
Y N Hospitalized for anything
Y N Kidney Disease
Y N Psychiatric Care
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Sexually Transmitted Disease
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Transplants
Y N Ulcers/Colitis

Please list any other conditions that would be important for us to know

______

______

Please check if your child is allergic to, or if he or she has had a reaction to any of the following:

☐ Aspirin ☐ Penicillin ☐ Latex ☐ Metal/Plastics ☐ Codeine

☐ Sulphur ☐ Food ☐ Local Anesthetic ☐ Tetracycline

☐ Erythromycin ☐ Other ______

______

DENTAL HISTORY

Does your child pre-medicate before dental procedures? If yes, please explain.

______

______

Has your child ever had an injury to his or her Mouth / Teeth / Chin (circle)

Please explain: ______

______

Have adenoids or tonsils been removed? YES ☐ NO ☐

Please explain: ______

______

Does your child have any missing or extra permanent teeth? YES ☐ NO ☐

______

List any musical instruments played

______

Has your child ever experienced pain/discomfort in his or her

jaw joint (TMJ/TMD)? YES ☐ NO ☐

Has your child ever experienced any of the following (please circle): clenching/grinding teeth; lip sucking/biting; mouth breathing; nail-biting; nursing/bottle habits; tongue thrust; thumb/finger sucking speech problems? Please explain.

______

______

Has an orthodontist been consulted previously? YES ☐ NO ☐

______

Has anyone in your family had orthodontic treatment? YES ☐ NO ☐

______

______

Has an orthodontist been consulted previously? YES ☐ NO ☐

____

Has anyone in your family had orthodontic treatment? YES ☐ NO ☐

____

____

What are the main goals you would like orthodontics to accomplish?

____

____

SIGNATURE

I understand that the information that I have given is correct to the best of my knowledge. It will be held in the strictest of confidence per HIPPA regulations. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover.

____

Signature Date

Richard T. Jones DDS, PS | Diplomate, American Board of Orthodontics

jonesorthodontics.com | p. (206) 542-6188 | f. (206) 546-0293

18550 Firlands Way North | Shoreline, WA 98133