DATA SHEET – MINOR (under 18)

ARLINGTON ORTHODONTICS
Love your smile

Patient Information

Today's Date _____

Patient's Name _____ Nickname _____

Address _____ Gender _____

_____ Birth Date _____ Age _____

Home Phone # _____ Hobbies / Sports _____

School _____ Grade _____ SS# _____

Patient's Dentist Name & City _____ Date of Last Cleaning _____

How did you hear about our office? _____

Responsible Party Information

Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Who will be responsible for the account? Name _____ Relation _____

Parent 1 Name _____

☐ Mother ☐ Father ☐ Other _____

Address _____

_____

Email: _____

Cell # _____ DOB _____

Employer _____ SS# _____

Occupation _____

Parent 2 Name _____

☐ Mother ☐ Father ☐ Other _____

Address _____

_____

Email: _____

Cell # _____ DOB _____

Employer _____ SS# _____

Occupation _____

Primary Orthodontic Insurance

Insured's Name _____

Relation to Patient _____

Insured's Birth Date _____

Insured's SS# _____

Insured's Employer _____

Insurance Company _____

Insured's Subscriber # _____

Secondary Orthodontic Insurance

Insured's Name _____

Relation to Patient _____

Insured's Birth Date _____

Insured's SS# _____

Insured's Employer _____

Insurance Company _____

Insured's Subscriber # _____

Dental History

What is your main orthodontic concern? _____

Yes No Has the patient ever had any significant dental problems? _____

Yes No Has the patient ever had periodontal / gum disease? _____

Yes No Does the patient have a thumb or tongue habit? _____

Yes No Does the patient feel self-conscious about his/her teeth? _____

Yes No Have any teeth ever been injured or knocked out? When? _____

Yes No Has the patient ever had orthodontic treatment in the past? When? _____

Yes No Has the patient seen an orthodontist recently? Who? _____

What is the patient's attitude towards orthodontic treatment? _____

Yes No Have any family members received orthodontic treatment? _____

How did they feel about the result? _____

Yes No Does the patient experience any jaw / TMJ pain? _____

Yes No Does the patient have any pending dental treatment planned with the dentist? _____

Yes No Are you aware that some appointments will be during work / school hours? _____

Medical History – Minor (under 18)

ARLINGTON ORTHODONTICS
Love your smile

Patient's Physician _____
Address _____

Yes No Is there any history of a major illness? _____
Yes No Is the patient taking any medications? _____
Yes No Does the patient have any heart problems? _____
Yes No Does the patient have any implanted pins, plates, or joint replacements that require premedication prior to dental treatment? _____
Yes No Does the patient need to take premedication prior to dental treatment? _____
Yes No Is the patient pregnant? _____

Is the patient allergic to any of the following: ___ Latex ___Acrylics ___Metals ___Penicillin
Please list any other drugs/materials the patient is allergic to: _____

Please place a checkmark below if the patient has ever had any of the following:

___ Abnormal bleeding/ Hemophilia
___ AIDS/HIV Positive
___ Angina
___ Arthritis
___ Artifical Joint
___ Blood Disorders
___ Bone Disorders
___ Cancer / Tumor
___ Congenital Heart Defect
___ Diabetes
___ Epilepsy
___ Fainting Spells
___ Headaches
___ Heart Problems
___ Hepatitis A, B, or C
___ High Blood Pressure
___ Jaundice
___ Liver Disease
___ Radiation / Chemo
___ Seizures
___ Tuberculosis

Yes No Has the patient ever had any illness, medical condition, or hospitalizations not listed above?
If yes, please explain _____

Yes No **Are there any precautions we need to take prior to dental treatment?**
If yes, please explain _____

Emergency Contact

Name (other than parents) _____ Relation _____
Address _____ Phone # _____
_____

I understand that the information I have provided is correct to the best of my knowledge, and it will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my medical status. I authorize release of any information to insurance carriers and to other healthcare providers.
I authorize the application for benefits on my behalf and payment of benefits to the office. I also authorize the doctor to complete an orthodontic evaluation and to perform any orthodontic / dental services that may be necessary during treatment.

Signature of Parent / Guardian: _____ Date: _____

Dr. Lindgren Signature: _____ Date: _____