Dr. Darrin Storms

Welcome!

Date: ______ / ______ / ______

TELL US ABOUT YOUR CHILD

Child's Name: ______________________ ☐ Male ☐ Female

Nickname: ______________ Date of Birth: ______________ Age: __________

School / Grade: ____________ / _____ Hobbies / Sports ______________________

Child's Home Address: ______________________ Home Phone: __________

____

Person accompanying child to their appointment today: ______________ Relationship? __________

Do you have legal custody of this child? ☐ Yes ☐ No

List brothers / sisters: ______________________ Age __________

______________________ Age __________

______________________ Age __________

PARENT / RESPONSIBLE PARTY INFORMATION

FATHER'S INFORMATION: ☐ Father ☐ Step-Father ☐ Guardian ☐ Grandfather ☐ Other__________

Are you to be listed as the primary or secondary financially responsible party? ☐ Primary ☐ Secondary

Name: ______________________ Date of Birth: __________

Mailing Address: ______________________ Home Phone: __________

______________________ Cell Phone: __________

Home E-Mail: ______________________

Employer: ______________________ Work Phone: __________

Job Title: ______________________ # yrs employed: __________

Work E-Mail: ______________________

Social Security No: __________ - __________ - __________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name______________

MOTHER'S INFORMATION: ☐ Mother ☐ Step-Mother ☐ Guardian ☐ Grandmother ☐ Other__________

Are you to be listed as the primary or secondary financially responsible party? ☐ Primary ☐ Secondary

Name: ______________________ Date of Birth: __________

Mailing Address: ______________________ Home Phone: __________

______________________ Cell Phone: __________

Home E-Mail: ______________________

Employer: ______________________ Work Phone: __________

Job Title: ______________________ # yrs employed: __________

Work E-Mail: ______________________

Social Security No: __________ - __________ - __________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name______________

Child's Dentist: ______________________ Date of last dental cleaning: ______________

What is your primary concem about your child's smile? ______________________

Whom may we thank for referring your child? ☐ Dentist ☐ Physician ☐ Friend ☐ Staff Member ☐ Other

Name: ______________________

Is the child experiencing any dental pain? ☐ Yes ☐ No Describe: ______________________

Has the child had any pain or tenderness in their jaw joints? ☐ Yes ☐ No Due to an accident? ☐ Yes ☐ No

Does the child have any clicking, popping, grinding or locking in your jaw joints? ☐ Yes ☐ No If so, where? ______________

Description of event, trauma or accident: ______________________

Any body piercings / jewelry on lips, cheeks, nose or tongue? ☐ Yes ☐ No If so, where? ______________

Is the child currently taking any prescription medications? ☐ Yes ☐ No If so, what? ______________

Is the child taking Fosamax for bone strengthening? ☐ Yes ☐ No

Regarding females of child bearing age: Pregnant? ☐ Yes ☐ No Number of months pregnant: ________months

Birth Control Pills? ☐ Yes ☐ No

MEDICAL and DENTAL HISTORY

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? ***Conditions listed in RED may require antibiotics prior to treatment***

Heart Attack	☐	Stroke	☐	Epilepsy	☐
Heart Murmur	☐	Hepatitis	☐	Abnormal Bleeding	☐
Congenital Heart Defect	☐	Diabetes	☐	Frequent Fever Blisters	☐
Mitral Value Prolapse	☐	Ulcers / Colitis	☐	Shingles	☐
Artificial Valves	☐	Asthma	☐	Kidney / Liver Problems	☐
Pacemaker	☐	Emphysema	☐	Frequent Headaches	☐
Rheumatic Fever	☐	Sinus Problems	☐	Psychiatric Therapy	☐
High Blood Pressure	☐	Scarlet Fever	☐	Drug / Alcohol Abuse	☐
Cancer	☐	Tuberculosis	☐	HIV+ / AIDS	☐

Other medical conditions not listed: ______________________

ALLERGIES

Penicillin	☐	Aspirin	☐	Local Anesthetics	☐
Amoxicillin	☐	Tylenol	☐	Codeine	☐
Tetracycline	☐	Ibuprofen	☐	Latex Sensitivity	☐

Other medication allergies not listed: ______________________

DENTAL HISTORY

Previous Orthodontic Treatment	☐	Gag Easily	☐	Tooth Sensitivity	☐
(When: ____________)		Tongue Thrusting Habit	☐	Bad Breath	☐
Gum Disease	☐	Thumb Sucking Habit	☐	How often do you brush per day? ______	
Bleeding Gums	☐	Oral Surgery	☐	How often do you floss per day? ______	

Other dental conditions not listed: ______________________

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address): ______________________

Relationship to patient: ____________ Home Phone: ______________ Cell Phone: ______________

REGARDING YOUR ORTHODONTIC INSURANCE *(Please complete an Orthodontic Insurance Information form)*

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes **Dr. Storms** to submit claims without obtaining my signature on each and every claim to be submitted.

NOTICE OF PRIVACY PRACTICES

We are dedicated to protecting your personal medical and dental information and following all provisions required by law. You are entitled to review our complete Privacy Notice which describes how we may use and disclose your medical and dental records while you are receiving care at **Storms Orthodontics**.

I understand the information that I have given is correct to the best of my knowledge and it my responsibility to inform this office of any changes in my address, employment or medical status. I also grant permission to discuss treatment recommendations with my dentist and discuss both medical and dental informartion including initial reports, progress reports and final reports regarding oral hygiene and/or treatment.

______________________ ______________

Signature of Parent /Legal Guardian Date

______________________ ______________

Doctor's Signature Date