Welcome to Tavarez Orthodontics!

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.

1. ABOUT YOUR CHILD Today's Date: _____

First Name: _____

Last Name: _____

Nickname: _____

Birth Date:_____ Age: _____ ❒ Male ❒ Female

School: _____ Grade: _____

Hobbies/Sports: _____

E-Mail Address: _____

Child's Home Address:_____

_____

2. WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relation: _____
Do you have legal custody of this child? ❒ Yes ❒ No

Whom may we Thank for Referring you? _____

List brothers/sisters with age: _____

_____

General Dentist: **«Dentist_Full_Name»**

Parent's Marital Status: ❒ Single ❒ Married ❒ Divorced

❒ Widowed ❒ Separated ❒ Partnered

3. ❒ Mother's Information: ❒ Step Mother ❒ Guardian

Name: _____ Birth date: _____

Email address: _____

Cell #: (____) _____ Other #: (____)_____

Employer: _____ Occupation: _____

❒ Father's Information: ❒ Step Father ❒ Guardian

Name: _____ Birth date: _____

Email address: _____

Cell #: (____) _____ Other #: (____)_____

Employer: _____ Occupation: _____

4. PERSON RESPONSIBLE FOR ACCOUNT

First Name: _____ Last Name: _____

Relation: _____

Billing address: _____

_____

Do you Own or Rent? (circle one) How Long? _____

Cell #: (____) _____ Other #: (____) _____

Employer: _____ Wk # (____) _____ Ext: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____) _____Ext: _____ Cell #: (____)_____

5. ORTHODONTIC INSURANCE - Primary:
Orthodontic coverage: ❒ Yes ❒ No Dental coverage: ❒ Yes ❒ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Primary Member ID#: _____

Insured's Name: _____ Relation: _____

Insured's Birth date: ____/____/____

Insured's Employer: _____

Secondary:
Orthodontic coverage: ❒ Yes ❒ No Dental coverage: ❒ Yes ❒ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Primary Member ID# : _____

Insured's Name: _____ Relation: _____

Insured's Birth date: ____/____/____

Insured's Employer: _____

Highlighted fields are required for 0% in-house financing

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

_____

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

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

List any musical instruments played: _____

Have adenoids 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

Does your child brush his/her teeth daily? ❒ Yes ❒ No

Floss his/her teeth daily? ❒ Yes ❒ No

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

Please list all drugs that your child is currently taking: _____

_____

Please list all drugs/things that your child is allergic to: _____

_____

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

❒ Yes ❒ No Abnormal Bleeding
❒ Yes ❒ No ADD/ADHD
❒ Yes ❒ No Drug Allergies
❒ Yes ❒ No Latex Allergy
❒ Yes ❒ No Plastic Allergy
❒ Yes ❒ No Any hospital Stays
❒ Yes ❒ No Any Operations
❒ Yes ❒ No Asthma
❒ Yes ❒ No Cancer
❒ Yes ❒ No Convulsions/Epilepsy
❒ Yes ❒ No Kidney/Liver Problems
❒ Yes ❒ No Handicaps/disabilities
❒ Yes ❒ No Congenital Heart Defect
❒ Yes ❒ No Rheumatic/Scarlet Fever
❒ Yes ❒ No Artificial Bones/Joints/Valves
❒ Yes ❒ No Tuberculosis (TB)
❒ Yes ❒ No Diabetes
❒ Yes ❒ No Metal/Nickel Allergy
❒ Yes ❒ No Hearing Impairment
❒ Yes ❒ No Heart Murmur
❒ Yes ❒ No Hemophilia
❒ Yes ❒ No Hepatitis
❒ Yes ❒ No HIV+/AIDS
❒ Yes ❒ No Lupus

Please discuss any medical problems that your child has had:

_____

_____

8. Has your child ever experienced any of the following?

❒ Yes ❒ No Lip Sucking/Biting
❒ Yes ❒ No Mouth Breather
❒ Yes ❒ No Nail Biting
❒ Yes ❒ No Thumb/finger Sucking
❒ Yes ❒ No Clenching/Grinding Teeth
❒ Yes ❒ No Speech Problems
❒ Yes ❒ No Tongue Thrust

Neighbor or Relative not living with you.

Name: _____

Phone: (_____) _____

Address

9. I understand that the information that 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 the medical status. I authorize the dental staff to perform the necessary dental services the patient may need. This office reserves the right to verify the credit status of potential patients or responsible party/guardian 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. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. This office is HIPAA Compliant and is committed to meeting or exceeding the standers of infection control mandated by OSHA, the CDC and the ADA

Signature: _____ Relation to patient: _____ Date: _____