300 Main Street
Groton, MA 01450
978-448-2300

DECOTEAU ORTHODONTICS

169 Kinsley Street
Nashua, NH 03060
603-589-9222

## PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

**CHILD'S NAME:** _____ Nick Name: _____ Date: _____
(Last / First / Middle)

Birthdate: _____ Age: _____ ☐ Male ☐ Female Home Phone #: _____

Address: _____
(Street / City / State / Zip)

Sports/Hobbies: _____ Child's Email: _____

School: _____ Grade: ____ List brothers / sisters with age: _____

**Who is accompanying your child today?** _____ Relation _____ Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you to our office? _____

## PARENT INFORMATION

**PARENT/GUARDIAN #1:** Mother ☐ Step Mother ☐ Guardian ☐ Other ☐ _____ Social Security #: _____-_____-_____

Name: _____ Birthdate: _____ Email: _____
(Last / First / Middle)

Mailing Address: _____
(Street / City / State / Zip)

Home Phone #: _____ Cell Phone #: _____ Cell Phone Provider: _____

Employer Name and Address: _____ Occupation: _____

**PARENT/GUARDIAN #2:** Father ☐ Step Father ☐ Guardian ☐ Other ☐ _____ Social Security #: _____-_____-_____

Name: _____ Birthdate: _____ Email: _____
(Last / First / Middle)

Mailing Address: _____
(Street / City / State / Zip)

Home Phone #: _____ Cell Phone #: _____ Cell Phone Provider: _____

Employer Name and Address: _____ Occupation: _____

**Parents Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

**Person responsible for account:** _____ Relation to patient: _____

Mailing Address: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____ Email: _____

## DENTAL INSURANCE INFORMATION

**Do you have orthodontic coverage? ☐ Yes ☐ No ( If no, skip to next section )**

**PRIMARY ORTHODONTIC INSURANCE** ***Insured's Name :*** _____ Birthdate: _____

Insurance Company Name: _____ Group #: _____ ID #: _____

Insurance Co. Address: _____ Phone #: _____

***Do you have dual coverage?*** Yes_____ No _____

**SECONDARY ORTHODONTIC INSURANCE** ***Insured's Name:*** _____ Birthdate: _____

Insurance Company Name: _____ Group #: _____ ID #: _____

Insurance Co. Address: _____ Phone #: _____

## EMERGENCY CONTACT INFORMATION

Name: _____ Phone #: _____ Relation to Patient: _____

## MEDICAL HISTORY

**PHYSICIAN:** _____ Date of Last Visit: _____
Address: _____ Phone #: _____

**ALLERGIES:**

Yes No Is your child allergic to any latex, metals, nickel or plastics? *Please list:*_____
Yes No Is your child allergic to any medication / things? *Please list:* _____

**Has your child ever had any of the medical conditions listed below:** Yes _____ No _____ *If yes, please circle:*

| | | | | |
|---|---|---|---|---|
| Abnormal Bleeding | Bone Disorders | Gastrointestinal Disorders | High/Low Blood Pressure | Psychiatric Problems |
| ADD or ADHD | Cancer/Tumor | Hearing Impairment | HIV/AIDS | Radiation/Chemotherapy |
| Anemia | Congenital Heart Defect | Heart Problems/Murmur | Kidney Problems | Rheumatic Fever |
| Artificial Bones/Joints/Valves | Diabetes | Hemophilia | Nervous Disorders | Severe/Frequent Headache |
| Asthma | Dizziness | Hepatitis/Liver Problems | Pneumonia | Sinus Problems |
| Autism | Epilepsy/Seizures | Herpes/Fever Blisters | Prolonged Bleeding | Tuberculosis |

Is your child taking any medication? *Please list:* _____
Is there a history of a major illness? *Please list:*_____
Has your child had any operations or been involved in a serious accident? *Please list:* _____
Are there any handicaps/disabilities that we should be aware of? _____
Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

## DENTAL HISTORY

**GENERAL DENTIST**: _____ Date of Last Visit: _____
What concerns you most about your child's teeth? _____

**Has your child ever had any of the habits listed below:** Yes _____ No _____ *If yes, please circle:*

| | | | | |
|---|---|---|---|---|
| Clenching Teeth | Thumb / Finger Habit | Lip Sucking | Mouth Breathing | Nail Biting |
| Grinding Teeth | Tongue Thrust | Lip Biting | Speech Problems | Bottle Habit |

Yes No Has your child ever been evaluated for orthodontic treatment? _____
Yes No Is your child sensitive or self-conscious about his/her teeth? _____
Yes No Has anyone in the family received orthodontic treatment? _____
If yes, how did they feel about the result? _____

Yes No Has your child ever experienced any unfavorable reaction to dentistry?_____
Yes No Is your child presently in any dental pain?_____
Yes No Is any part of your child's mouth sensitive to temperature or pressure? Where? _____
Yes No Have there been any injuries to face, mouth, or teeth?_____
Yes No Has your child been informed of any missing or extra teeth? _____
Yes No Has your child ever lost or chipped any permanent teeth? _____

Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning?_____
Yes No Does your child ever experience jaw clicking or popping? _____
Yes No Does your child experience "tension" headaches? _____

Yes No Does your child brush daily? _____
Yes No Do gums bleed when brushing? _____

I have truthfully answered all the above questions and agree to inform this office of any changes in my child's medical or dental history. I understand that diagnostic records may be used for educational and promotional purposes. In addition, I authorize the Doctors of Decoteau Orthodontics and staff to perform the necessary dental services my child needs.

*Parent/Guardian Signature*: _____ *Date*: _____

I understand that I am responsible for payment of services rendered and also for paying any co-payments and deductibles that my insurance does not cover. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

*Parent/Guardian Signature*: _____ *Date*: _____

This office reserves the right to verify the credit status of patients and/or their parents prior to extending credit for orthodontic fees and may, at the discretion of the office, use the services of credit reporting services.

*Parent/Guardian Signature*: _____ *Date*: _____