DR. RICK BALLARD
Orthodontist

PATIENT INFORMATION FOR MINORS

Please complete this form front and back

Ballard ORTHODONTICS

About Your Child

Todays Date: ____/___/_____

Patients Name:_____ Preferred Name:_____ ☐ Male ☐ Female Birthdate___/___/___

Address:_____ City:_____ State:_____ Zip:_____ Childs Home Phone:_____

School:_____ Grade:_____ Hobbies or interests:_____

Siblings names and ages: _____

Have we seen any other family members? ☐ Yes ☐ No If yes who? _____

How did you hear about our practice? _____

Reason for orthodontic consultation:_____

Who noticed an orthodontic problem ☐ Patient ☐ Parent ☐ Dentist ☐ Other _____

Family Information

Mothers Name:_____ Birthdate___/___/_____ SS# ____-___-_____ Legal Custody: ☐ Yes ☐ No

☐ Mother ☐ Step Mother ☐ Legal Guardian Email Address: _____

Home Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____

Occupation:_____ Employer:_____ How Long:_____ Work Phone #:_____

Fathers Name:_____ Birthdate___/___/_____ SS# ____-___-_____ Legal Custody: ☐ Yes ☐ No

☐ Father ☐ Step Father ☐ Legal Guardian Email Address: _____

Home Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____

Occupation:_____ Employer:_____ How Long:_____ Work Phone #:_____

Parents marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Remarried

Responsible party name (if different than above): _____ Birthdate____/___/_____ Relation: _____

SS# ____-___-_____ Legal Custody: ☐ Yes ☐ No Email Address: _____

Home Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____

Occupation:_____ Employer:_____ How Long:_____ Work Phone #:_____

Person responsible for making appointments:_____ Relation:_____

In case of emergency please contact: _____ Phone #:_____

Dental Insurance

Do you have dental insurance? ☐ Yes ☐ No

Does this policy have orthodontic coverage for this minor? ☐ Yes ☐ No ☐ Don't Know

Primary insurance: Name of Insurance Carrier:_____ Employer:_____

Carrier Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____

Primary Insured Full Name:_____ Primary Birthdate____/___/_____

Relationship to patient:_____ Member ID#: _____ Group #:_____

Secondary insurance (if applicable): Name of Insurance Carrier:_____ Employer:_____

Carrier Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____

Primary Insured Full Name:_____ Primary Birthdate____/___/_____

Relationship to patient:_____ Member ID#: _____ Group #: _____

Growth & Misc Information

Has puberty begun? ☐ Yes ☐ No Has menstruation begun? (Girls) ☐ Yes ☐ No Has voice changed? (Boys) ☐ Yes ☐ No

Mother's Height: _____ Father's height: _____ Do you feel growth is complete? ☐ Yes ☐ No

What are the main concerns about your child's teeth? _____

Have parents or siblings had orthodontic treatment? ☐ Yes ☐ No

Has your child consulted an orthodontist previously? ☐ Yes ☐ No Who? _____

Has there been previous orthodontic treatment? ☐ Yes ☐ No Please describe: _____

Dental History

Patients Dentist's Name:_____ City:_____ Phone #:_____ Last Visit: ____/____/____

Did they refer you to our office? ☐ Yes ☐ No How often does patient brush? _____ Floss?_____

Frequency of dental checkups: ☐ Twice a year ☐ Once a year ☐ As needed ☐ Never

Patients interest in orthodontic treatment: ☐ Eager for treatment ☐ Willing if necessary ☐ Dreading but agrees ☐ Unwilling

Please check if there is a history of:

☐ Clenching/grinding	☐ Lip sucking/biting	☐ Tension headaches	☐ Bleeding gums
☐ Thumb sucking	☐ Tongue thrust	☐ Speech problems	☐ Multiple cavities
☐ Nail biting	☐ Jaw joint pain (TMJ)	☐ Mouth breathing	☐ Poor oral hygiene

Is any part of mouth sensitive to temperature or pressure? ☐ Yes ☐ No Explain: _____

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Have any primary or permanent teeth been removed? ☐ Yes ☐ No Why? _____

Has your child had any facial or dental injuries? ☐ Yes ☐ No Explain: _____

Medical History

Patients Physician's Name:_____ City:_____ Phone #:_____ Last Visit: ____/____/____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Is patient currently under physician's care? ☐ Yes ☐ No Explain: _____

Is patient currently taking any medications or vitamins? ☐ Yes ☐ No List: _____

Please list **ANY & ALL** known allergies you are aware of (ex: latex, metals, foods, plastics, drugs/medications)_____

_____

Is the patient currently, or have previously taken any medications known as Bisphosphonates or bone density medications? (ex: Aclast, Actonel, Actonel+Ca, Aredia Atelvia, Binosta, Bonefos, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa)

☐ Yes ☐ No When?: _____

Please check if there is a history of:

☐ ADD/ADHD	☐ Blood disorder	☐ Developmental disorder	☐ Hemophilia	☐ Sleep disordered breathing
☐ Aids/HIV Positive	☐ Bone disorder	☐ Diabetes	☐ Hepatitis	☐ Stomach ulcers
☐ Airway concerns	☐ Cancer	☐ Epilepsy	☐ Lupus	☐ Thyroid problems
☐ Anemia	☐ Chemical dependency	☐ Fainting	☐ Nervous system problem	☐ Tobacco habit
☐ Anxiety/Depression	☐ Chemo/radiation	☐ Handicap/disability	☐ Psychiatric Care	☐ Tonsillitis
☐ Asthma	☐ Circulatory problems	☐ Headaches (frequent)	☐ Respiratory disease	☐ Tonsils/adenoids removed
☐ Autism	☐ Cough (persistent)	☐ Heart problems	☐ Rheumatic/scarlet fever	

Please use this space to explain any above answers or list any additional health information we should know about:_____

_____

_____

Has the patient had any surgeries or hospital stays? ☐ Yes ☐ No Explain: _____

_____

Financial and Treatment Authorization

I affirm that the information I have given is accurate and complete to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's personal information or health status. I will not hold this office, our doctors or staff responsible for any errors or omissions I have made in the completion of this form. **Signature:** _____ **Date:** ____/___/____

This office accepts insurance, I assign directly to Dr. Ballard all insurance benefits otherwise payable to me. 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. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. **Signature:** _____ **Date:** ____/___/____

This office reserves the right to verify the credit status of potential patients and/or parents of the patients prior to extending credit for treatment fees and may use the services of one or more credit reporting agencies. **Signature:** _____ **Date:** ____/___/____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by ASHA, the CDC and the ADA.