Panucci Orthodontics

Farming Smiles

5800 Willow Bend Road, Union, WV 24983
304-772-3707

Welcome to Our Office!

Tell Us About Your Child

Today's Date: _____ Nickname: _____ Male Female

Child's Name: _____
Last First Middle

Birthdate: ___/___/___ Age: _____ Social Security Number (SSN): _____

Child's Home Phone #: _____ Child's Cell#: _____

Child's Home Address: _____
Street City State Zip

School: _____ Grade: _____ Child's Email: _____

Hobbies/Sports:

Who is accompanying your child today? _____

Name: _____ Relationship: _____

Do you have legal custody of this child? Yes No Custodial Parent: _____

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

List Siblings	Date of Birth	Age	Sex: M / F
	/ /		
	/ /		
	/ /		
	/ /		

List any family members who have been or are in treatment in our office: _____

Parents' Marital Status (Circle One): Single Partnered Divorced Married Separated Widowed

Mother's Information

Name: _____ Birthdate: ___/___/___

Address: _____

Cell #: _____ Home # (if not cell): _____

SSN: _____ Email: _____

Employer: _____ Occupation: _____ Work #: _____

Father's Information

Name: _____ Birthdate: ___/___/___

Address: _____

Cell #: _____ Home # (if not cell): _____

SSN: _____ Email: _____

Employer: _____ Occupation: _____ Work #: _____

Stepmother/Guardian Information

Name: _____ Birthdate: ___/___/___

Cell #: _____ Home # (if not cell): _____

SSN: _____ Email: _____

Employer: _____ Occupation: _____ Work #: _____

Stepfather/Guardian Information

Name: _____ Birthdate: ___/___/___

Cell #: _____ Home # (if not cell): _____

SSN: _____ Email: _____

Employer: _____ Occupation: _____ Work #: _____

Continued on Back

Panucci Orthodontics

What main concerns do you want to address with orthodontic treatment? _____

_____

Has your child ever been evaluated or had orthodontic treatment before? Yes No
Describe if yes: _____

Name of patient's general dentist: _____ Date of last dental visit: _____

Does your child require antibiotic premedication before dental procedures? Yes No

Has your child ever experienced any of the following?

Y N Clenching/Grinding
Y N Tongue Thrust
Y N Lip Sucking/Biting
Y N Mouth Breathing
Y N Nail Biting
Y N Nursing Bottle Habit
Y N Speech Problems
Y N Thumb/Finger Sucking
Until what age? _____
Y N Pacifier Habit
Until what age? _____

Does your child experience frequent headaches? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No
Describe if yes: _____

List any musical instruments played: _____

Has your child been informed of any missing, impacted or extra permanent teeth? Yes No
Describe if yes: _____

Has your child had any pain/tenderness/noises in his/her jaw joint (TMJ/TMD), ears, temples or cheeks? Yes No
Describe if yes: _____

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

Y N Abnormal Bleeding
Y N ADD/ADHD
Y N Anemia
Y N Arthritis
Y N Artificial Joints/Valves
Y N Asthma
Y N Blood Disease
Y N Bone Disorders
Y N Cancer
Y N Diabetes
Y N Epilepsy/Convulsions
Y N Endocrine Problems
Y N Emotional Problems
Y N Frequent Colds or Flu
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur/Heart Problems
Y N Hemophilia
Y N Hepatitis/Jaundice
Y N Herpes
Y N HIV/AIDS
Y N Kidney/Liver Problems
Y N Lupus
Y N Mitral Valve Prolapse
Y N Rheumatic/Scarlet Fever
Y N Tuberculosis
Y N Tonsillitis/Adenoiditis
Y N Tonsils Removed:
Age: _____
Y N Adenoids Removed:
Age: _____

If answered yes to any above, please explain: _____

_____

Child's Physician: _____ Phone: _____ Date last visit: _____

Is your child currently under the care of a physician? Yes No
Describe if yes: _____

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

_____

Please list all drugs/materials that your child is allergic or sensitive to: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services, including x-rays, my child may need.

_____

Signature of Parent or Guardian **Date**

HEALTH HISTORY UPDATES

Date Reviewed	Reviewed By	List **ANY** Changes To This Form

Patient Name: _____

Panucci Orthodontics

5800 Willow Bend Road, Union, WV 24983
304-772-3707

Individual Responsible For Account

Name: _____ Relationship: _____

Billing Address: _____
Street City State Zip

Cell #: _____ Home # (if not cell) _____ SSN: _____

Email address: _____ _____

Employer: _____ Work #: _____

Individuals Responsible For Scheduling Appointments

Name: _____ Relationship: _____

Cell #: _____ Home # (if not cell) _____ Work# _____

Email address: _____

and/or

Name: _____ Relationship: _____

Cell #: _____ Home # (if not cell) _____ Work# _____

Email address: _____

Primary Dental Insurance

Employer/Company Name: _____ Employer Phone#: _____

Insurance Company Name: _____

Insurance Company Phone Number: _____ Group, Policy, Plan or Local #: _____

Employee's Name: _____ Relationship: _____

Employee's SSN: _____ Employee's Birthday: _____

Secondary Dental Insurance

Employer/Company Name: _____ Employer Phone#: _____

Insurance Company Name: _____

Insurance Company Phone Number: _____ Group, Policy, Plan or Local #: _____

Employee's Name: _____ Relationship: _____

Employee's SSN: _____ Employee's Birthday: _____

Emergency Contact Information

Name of nearest relative that hasn't been previously listed:

Name: _____ Relationship to patient: _____

Home#: _____ Cell#: _____ Email: _____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment, deductible or portion that my insurance does not cover.

_____

Signature of Parent or Guardian Date

Payment arrangements are made for your convenience and are to be made until the full amount of your contract has been paid, even when treatment is completed prior to balance being paid in full. We do report delinquencies to the credit bureaus.

_____

Signature of Parent or Guardian Date