



Welcome to Monroe Orthodontics! We look forward to providing you with the highest level of care and service during your orthodontic journey. Please complete this form prior to your first appointment - the New Patient Exam. Thank you!

**NEW PATIENT FORM — Child** Today's Date

Who is accompanying the child to their New Patient Exam? (name) \_\_\_\_\_  
Their relation to the child is \_\_\_\_\_ Do they have legal custody of this child? (circle) Yes / No  
Whom may we thank for referring you? \_\_\_\_\_

**Information About Your Child**

Name (first /mi /last) \_\_\_\_\_ (circle) Female / Male  
Preferred Name/ Nickname \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_ Age \_\_\_\_\_  
Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Child's Home Phone ( ) \_\_\_\_\_  
Child's Home Address (street/apt #/city/state/zip) \_\_\_\_\_  
School Name \_\_\_\_\_ Grade \_\_\_\_\_  
Sports \_\_\_\_\_ Hobbies \_\_\_\_\_  
Musical Instruments \_\_\_\_\_ Siblings \_\_\_\_\_  
Child's General Dentist (Name/ City) \_\_\_\_\_  
Dentist's Phone ( ) \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Is the child currently under the care of a physician? (circle) Yes / No  
Child's Physician (Name/ City) \_\_\_\_\_  
Physician's Phone ( ) \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

**Parent Information**

Who is responsible for the account? \_\_\_\_\_  
Parent's Marital Status (circle) Married Divorced Separated Single Widowed Partnered

**FATHER'S INFORMATION**

(circle) Father Stepfather Guardian  
Name (first /mi /last) \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_  
Home Address (if different from child's) \_\_\_\_\_  
Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Father's Work Phone ( ) \_\_\_\_\_  
Father's Home Phone ( ) \_\_\_\_\_ Father's Cell Phone ( ) \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

If you have Orthodontic Insurance Coverage for the child, please fill out below:

Insurance Company Name \_\_\_\_\_ Insurance Phone ( ) \_\_\_\_\_  
Insurance Address (street/suite/city/state/zip) \_\_\_\_\_  
Group # (Plan, Local or Policy #) \_\_\_\_\_ Identification # \_\_\_\_\_

**Parent Information — cont.**

**MOTHER'S INFORMATION**

(circle) **Mother**    **Stepmother**    **Guardian**

**Name** (first /mi /last) \_\_\_\_\_ **Date of Birth** (mm/dd/yy) \_\_\_\_\_

**Home Address** (if different from child's) \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Mother's Work Phone** (    ) \_\_\_\_\_

**Mother's Home Phone** (    ) \_\_\_\_\_ **Mother's Cell Phone** (    ) \_\_\_\_\_

**Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_

*If you have Orthodontic Insurance Coverage for the child, please fill out below:*

**Insurance Company Name** \_\_\_\_\_ **Insurance Phone** (    ) \_\_\_\_\_

**Insurance Address** (street/suite/city/state/zip) \_\_\_\_\_

**Group #** (Plan, Local or Policy #) \_\_\_\_\_ **Identification #** \_\_\_\_\_

**Child's Dental & Medical History**

What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_

Has the child ever been evaluated or had orthodontic treatment before? (circle) **Yes**    **No**

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

Does the child require antibiotics before dental treatment? **Yes**    **No**

Have their adenoids or tonsils been removed? **Yes**    **No**

Does the child have any missing or extra permanent teeth? **Yes**    **No**

Has the child ever had any pain/tenderness in their jaw joint (TMJ/TMD)? **Yes**    **No**

Does the child brush their teeth daily? **Yes**    **No**

Does the child floss their teeth daily? **Yes**    **No**

Has the child started puberty? **Yes**    **No**

Has the female child started menstruation? **Yes**    **No**

Are the child's immunizations current? **Yes**    **No**

How would you describe the child's current physical health? (circle) **Good**    **Fair**    **Poor**

Please list the drugs that the child is currently taking: \_\_\_\_\_

Is the child allergic to the following? (circle for 'Yes')    **Latex**    **Nickel / Metals**    **Plastics**

Please list any drugs or additional things that the child is allergic to: \_\_\_\_\_

**Dental & Medical History — cont.**

Is there anything you would like to discuss with the doctor privately? Yes    No

Please list and discuss any serious medical problems your child has now or has had: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please circle yes or no to the following habits or conditions that your child has now or has had:

Abnormal Bleeding	Y	N	Convulsions	Y	N	Kidney Problems	Y	N
ADD / ADHD	Y	N	Diabetes	Y	N	Liver Problems	Y	N
AIDS / HIV +	Y	N	Epilepsy	Y	N	Mitral Valve Prolapse	Y	N
Hospital Stay or Operation	Y	N	Handicaps / Difficulties	Y	N	Prosthetics	Y	N
Artificial Bones /Joints /Valves	Y	N	Hearing Impairment	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Heart Murmur	Y	N	Scarlet Fever	Y	N
Cancer	Y	N	Hemophilia	Y	N	Sickle Cell Disease /Traits	Y	N
Congenital Heart Defect	Y	N	Hepatitis	Y	N	Tuberculosis (TB)	Y	N

Please circle yes or no to the following habits or conditions that your child has now or has had:

Breast Fed	Y	N	Nail Biting	Y	N	Tongue Thrust	Y	N
Clenching / Grinding Teeth	Y	N	Nursing Bottle Habits	Y	N	Used Pacifier	Y	N
Lip Sucking / Biting	Y	N	Speech Problems	Y	N			
Mouth Breather	Y	N	Thumb / Finger Sucking	Y	N			

**EMERGENCY CONTACT**

Nearest relative not living with patient \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone (    ) \_\_\_\_\_ Cell / Other Phone (    ) \_\_\_\_\_

**AUTHORIZATION**

This office reserves the right to verify the credit status of potential patients and/or parents 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 my 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. I hereby authorize Monroe Orthodontics to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Monroe Orthodontics is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC, and the ADA.