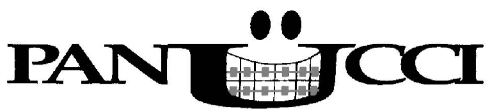
Welcome to our office!



Donna Panucci, DDS

Orthodontics for Adults & Children

Come smile with us!

Tell Us About Your Child

Today's Date: ______________________ Nickname: ______________________ Male Female

Child's Name: ____

Last First Middle

Birthdate: ____ / ____ / ____ Age: ________ Social Security #: ______________________

School: ______________________ Grade: ______________________

Hobbies/Sports: ____

Child's Home Phone #: ____

Child's Home Address: ____

Street City State Zip

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: ______________________

____

Parent's Marital Status: Single Partnered Divorced Married Separated Widowed

Mother's Information

Name: ______________________ Birthdate: ____ / ____ / ____ SS#: ______________________

Home#: ______________ Work#: ______________ Cell or Alternate#: ______________

Employer: ______________________ Occupation: ______________ Length of Service: ________

Father's Information

Name: ______________________ Birthdate: ____ / ____ / ____ SS#: ______________________

Home#: ______________ Work#: ______________ Cell or Alternate#: ______________

Employer: ______________________ Occupation: ______________ Length of Service: ________

Stepmother/Guardian Information

Name: ______________________ Birthdate: ____ / ____ / ____ SS#: ______________________

Home#: ______________ Work#: ______________ Cell or Alternate#: ______________

Employer: ______________________ Occupation: ______________ Length of Service: ________

Stepfather/Guardian Information

Name: ______________________ Birthdate: ____ / ____ / ____ SS#: ______________________

Home#: ______________ Work#: ______________ Cell or Alternate#: ______________

Employer: ______________________ Occupation: ______________ Length of Service: ________

Patient Name: ______________________

Patient Birthday: ______________________

Person Responsible For Account

Name: ______________________ Relationship: ______________________

Billing Address: ______________________
Street City State Zip

Previous Address: ______________________
(If less than 3 years) Street City State Zip

Home #: ______________________ Work #: ______________________ Cell or Alternate #: ______________________

Employer: ______________________ Social Security #: ______________________

Who is responsible for scheduling appointments?

Name: ______________________ Relationship: ______________________

Home Phone #: ______________________ Work #: ______________________ Cell or Alternate #: ______________________

and/or

Name: ______________________ Relationship: ______________________

Home Phone #: ______________________ Work #: ______________________ Cell or Alternate #: ______________________

Primary Dental Insurance

Employer/Company Name: ______________________ Employer Phone#: ______________________

Employer/Company Address: ______________________
Street City State Zip

Insurance Company Name: ______________________

Insurance Company Address: ______________________

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

Employee Name: ______________________ Relationship: ______________________

Employee Address: ______________________
Street City State Zip

Employee Home #: ______________________ Employee Birthdate: ______________________ Employee SS#: ______________________

Secondary Dental Insurance

Employer/Company Name: ______________________ Employer Phone#: ______________________

Employer/Company Address: ______________________
Street City State Zip

Insurance Company Name: ______________________

Insurance Company Address: ______________________

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

Employee Name: ______________________ Relationship: ______________________

Employee Address: ______________________
Street City State Zip

Employee Home #: ______________________ Employee Birthdate: ______________________ Employee SS#: ______________________

This office reserves the right to verify the credit status of potential patients and/or parents prior to extending payment plan and may use the services of one or more credit reporting agencies.

____

Signature of Parent or Guardian Date

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

PANUCCI
Donna Panucci, DDS
Orthodontics for Adults & Children

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 need antibiotic premedication before dental procedures? Yes No

Has your child ever experienced any of the following?

Y N Clenching/Grinding	Y N Nail Biting	Y N Thumb/Finger Sucking
Y N Tongue Thrust	Y N Nursing Bottle Habit	Until what age? ______
Y N Lip Sucking/Biting	Y N Speech Problems	Y N Pacifier Habit
Y N Mouth Breathing		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 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 Cancer	Y N Heart Murmur/Heart Problems	Y N Rheumatic/Scarlet Fever
Y N ADD/ADHD	Y N Diabetes	Y N Hemophilia	Y N Tuberculosis
Y N Anemia	Y N Epilepsy/Convulsions	Y N Hepatitis/Jaundice	Y N Tonsillitis/Adenoiditis
Y N Arthritis	Y N Endocrine Problems	Y N Herpes	
Y N Artificial Joints/Valves	Y N Emotional Problems	Y N HIV/AIDS	Y N Tonsils Removed:
Y N Asthma	Y N Frequent Colds or Flu	Y N Kidney/Liver Problems	Age: ______
Y N Blood Disease	Y N Handicaps/Disabilities	Y N Lupus	Y N Adenoids Removed:
Y N Bone Disorders	Y N Hearing Impairment	Y N Mitral Valve Prolapse	Age: ______

If answered yes to any above, please explain: ______

Child's Physician: ______ Ph#: ______ 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 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