www.webuildsmileappeal.com

For Children: Welcome to Our Practice

SMILE APPEAL ORTHODONTICS
MARK L. YOUNGKER, DDS, MS

1. TELL US ABOUT YOUR CHILD

Today's Date: _____ DOB: _____

Child's Name: Age: _____

_____
FIRST M.I. LAST

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Home/Cell Ph #: _____

Soc. Sec. #: _____

Child's Home Address:

_____
APT #

_____
CITY STATE ZIP

Siblings:

Name: _____ Age: _____

Name: _____ Age: _____

2. WHO IS WITH THE CHILD TODAY?

Name: _____

Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Who may we thank for referring you? _____

_____

Other family members seen by us:

_____

Parent's Marital Status: _____

(single, married, divorced)

Previous/Present Dentist: _____

Address: _____

Phone #: _____ Last Visit: _____

3. MOTHER'S INFORMATION

Name: _____

Work Ph #: _____ Ext.: _____ Home Ph #: _____

Employer: _____

Driver's License #: _____

S.S. #: _____

FATHER'S INFORMATION

Name: _____

Work Ph #: _____ Ext.: _____ Home Ph #: _____

Employer: _____

Driver's License #: _____

S.S. #: _____

4. RESPONSIBLE PARTY INFO

Name: _____

Billing Address: _____

_____
CITY STATE ZIP

Work #: _____ Ext.: _____

Home/Cell Ph#: _____

Email: _____

Employer: _____

Driver's License #: _____

S.S. #: _____

WHO IS RESPONSIBLE FOR MAKING APPTS?

Name: _____

Home/Cell Ph #: _____

5. PRIMARY DENTAL INSURANCE

Insurance Name: _____

Insurance Address: _____

_____

Insurance Co. Ph #: _____

Group/Policy #: _____

_____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

S.S. #: _____

Orthodontic Coverage: ☐ Yes ☐ No

SECONDARY DENTAL INSURANCE

Insurance Name: _____

Insurance Address: _____

_____

Insurance Co. Ph #: _____

Group/Policy #: _____

_____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

S.S. #: _____

Orthodontic Coverage: ☐ Yes ☐ No

www.webuildsmileappeal.com

For Children: Health History

SMILE APPEAL ORTHODONTICS
MARK L. YOUNGKER, DDS, MS

6. Why did you bring the child to the orthodontist today?

- Has the child ever had a serious problem associated with dental work? ☐ Yes ☐ No
- Is the child's water fluoridated? ☐ Yes ☐ No
- Is the child taking fluoridated supplements? ☐ Yes ☐ No
- **Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)?** ☐ Yes ☐ No
- Does the child brush teeth daily? ☐ Yes ☐ No
- Do they floss their teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Last Visit: _____

- Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's health: ☐ GOOD ☐ FAIR ☐ POOR

Please list all drugs the child is currently taking: _____

_____

_____

_____

Please list all drugs the child is allergic to: _____

_____

_____

_____

7. Has the child ever had any of the following medical problems?

YES/NO		YES/NO	
☐ ☐	Heart Murmur	☐ ☐	Congenital Heart Defects
☐ ☐	Cancer	☐ ☐	Convulsions/Epilepsy
☐ ☐	Diabetes	☐ ☐	Abnormal Bleeding
☐ ☐	Rheumatic Fever	☐ ☐	Hearing Impairment
☐ ☐	HIV+/AIDS	☐ ☐	Any Operations
☐ ☐	Hemophilia	☐ ☐	Any Stays in Hospital
☐ ☐	Asthma	☐ ☐	Kidney/Liver Problems
☐ ☐	Hepatitis	☐ ☐	Handicaps/Disabilities
☐ ☐	Tuberculosis	☐ ☐	Allergies to Any Drugs
☐ ☐	Prosthesis	☐ ☐	History of Scarlet Fever

Please discuss any serious medical problems that the child has had:

_____

_____

8. Does the child have any of the following habits?

- ☐ ☐ Thumb Sucking/Finger Sucking
- ☐ ☐ Lip Sucking/Biting
- ☐ ☐ Nail Biting
- ☐ ☐ Nursing Bottle Habits

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

9. I certify that the information that I have given is correct to the best of my knowledge, and I understand that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent/Guardian Date

The parent/guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials: _____ Date: _____

Doctor Comments: _____

_____

_____

Medical History Update:

1. Date: _____ Signature: _____

Comments: _____

2. Date: _____ Signature: _____

Comments: _____