Print Form

256 N. San Mateo Dr., #1
Cross Street: E. Santa Inez
650-343-3603

WELCOME

TO THE ORTHODONTIC OFFICE OF

Drs. Tom Ellerhorst & Adrian Vogt

We would like to welcome you to our office. The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.

TELL US ABOUT YOUR CHILD

Today's Date:
Name: LAST FIRST MI
Child prefers to be called:

☐ Male ☐ Female
DOB: Age:

SS#

Home Address:
CITY STATE ZIP

Hm #: ( ) CP # ( )
Email:

Whom may we thank for referring you?
Name of General Dentist

MOTHER/GUARDIAN INFORMATION

Name:
Employer:
Wk #: ( ) CP #: ( )
Email
DOB: SS#

FATHER/GUARDIAN INFORMATION

Name:
Employer:
Wk #: ( ) CP #: ( )
Email
DOB: SS#

PRIMARY DENTAL INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No ☐ Unknown
Insurance Name:
Insurance Address:
Insurance Ph #: ( )
Group # (Plan, Local, or Policy #):
Insured's Name:
Relationship to Patient:
Insured's DOB: ID #:
Insured's Employer:

SECONDARY DENTAL INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No ☐ Unknown
Insurance Name:
Insurance Address:
Insurance Ph #: ( )
Group # (Plan, Local, or Policy #):
Insured's Name:
Relationship to Patient:
Insured's DOB ID #
Insured's Employer:

In the rare event of an emergency, is there someone who lives near you that we should contact?

His/Her Name:
Relation:
Wk#: ( ) Hm#: ( )

****What are the main orthodontic concerns you would like addressed today?**

IS YOUR CHILD ALLERGIC TO LATEX? ☐ Yes ☐ No

Metals (jewelry etc?) ☐ Yes ☐ No

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

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

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

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician:

Phone #: (___) _____ Date of Last Visit: _____

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

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Please list all medications your child is currently taking:

Please list all allergies your child has:

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

☐ Yes ☐ No	Abnormal Bleeding
☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	ADD/ADHD
☐ Yes ☐ No	Heart Murmur
☐ Yes ☐ No	Any Hospital Stays
☐ Yes ☐ No	Hemophilia
☐ Yes ☐ No	Hepatitis/HIV+/AIDS
☐ Yes ☐ No	Artificial Bones/Joints/Valves
☐ Yes ☐ No	Kidney/Liver Problems
☐ Yes ☐ No	Asthma
☐ Yes ☐ No	Cancer
☐ Yes ☐ No	Rheumatic/Scarlet Fever
☐ Yes ☐ No	Congenital Heart Defect
☐ Yes ☐ No	Convulsions/Epilepsy
☐ Yes ☐ No	Tuberculosis (TB)
☐ Yes ☐ No	High/Low Blood Pressure

Please discuss any medical problems your child has had:

Has your child ever experienced any of the following?

☐ Yes ☐ No	Clenching/Grinding Teeth
☐ Yes ☐ No	Lip Sucking/Biting
☐ Yes ☐ No	Mouth Breather
☐ Yes ☐ No	Nail Biting
☐ Yes ☐ No	Speech Problems
☐ Yes ☐ No	Thumb/Finger Sucking
☐ Yes ☐ No	Tongue Thrust

I understand that the information that 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 understand that I am responsible for the full orthodontic fee (not my insurance company). We will be happy to assist you in claiming orthodontic benefits through your insurance plan. Insurance estimates are estimates only and are not a guarantee of payment. I also acknowledge that I have reviewed a copy of the Notice of Privacy Practices. This office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

By signing below, I give permission to the orthodontic office of Tom Ellerhorst, D.D.S., M.S.D. and staff to examine and treat my child. I also maintain full medical custody and am legally authorized to grant consent.

_____ _____

Signature **Date**

(You will be asked to verify and sign this form at the Initial Exam appointment.)

OFFICE USE ONLY OFFICE USE ONLY ***OFFICE USE ONLY*** OFFICE USE ONLY

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

Doctor's Comments: Initials: _____ Date: _____