Bancroft Orthodontics

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Date: _____

Patient Information

Patient Name: _____ Current Dentist: _____
Nickname: _____ Dentist Phone #: _____
Birthdate: _____ Age:_____ Physician: _____
School: _____ Grade: _____
Home address: _____ Referred by: _____
City, State, Zip: _____

Confirmation Preference: ☐ Text ☐ E-mail ☐ Phone Call
Home Phone: _____ Cell Phone: _____ Cell Provider: _____
E-mail: _____

Who is responsible for making appointments?
Name:_____
Best time and number to call: _____

Mother
Name: _____
Phone #: _____
Employer: _____
Occupation: _____
Work #: _____ ext: _____
E-mail: _____
Marital status: Single Married Divorced Widowed Separated

Father
Name: _____
Phone #: _____
Employer: _____
Occupation: _____
Work #: _____ ext: _____
E-mail: _____
Marital status: Single Married Divorced Widowed Separated

Who is responsible for making payments?
Name: _____
Contact information: _____

Orthodontic Insurance
Insurance Company: _____ Insurance Co. Phone #:_____
Subscriber's Name: _____ Subscriber's Birthdate: _____
Group #: _____ ID#:_____

For office use only - Please continue to next page

Dentition Status: Primary Mixed Permanent
Molar Class: Cl I End-on Cl II Full-step Cl II Super Cl I Cl III N/A
Canine Class: Cl I End-on Cl II Full-step Cl II Super Cl I Cl III N/A
Condition: Crowding Spacing Overbite:_____ Overjet:_____ Impactions
Treatment: Comprehensive Tx Phase I Phase II Limited Tx Recall
Modality: Twin Damon Invisalign

CONFIDENTIAL - Dental & Health History

Your child's overall health as well as any medications, which your child takes, could have an important interrelationship with the dental care your child receives. Please answer the following questions completely.

How often does your child brush? _____ How often does your child floss? _____

Is your child's water fluoridated?	Yes No
Does your child take fluoride supplements?	Yes No
Does your child:	
Suck thumb/finger	Yes No
Suck/Bite lip	Yes No
Bite/Chew nails	Yes No
Chew hard objects	Yes No
Grind teeth	Yes No
Clench jaws	Yes No

Has child had difficulty with previous dental visits? _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? _____

Does your child have a latex allergy or any other allergy?

_____

Is child currently taking any medications? Yes No (If yes, please list)

_____

Has your child ever had any of the following: (if yes please explain below)*

Abnormal Bleeding	Yes No	Asthma	Yes No
Cancer	Yes No	Congenital heart Defect	Yes No
Convulsions/Epilepsy	Yes No	Diabetes	Yes No
Handicaps/Disabilities	Yes No	Heart Murmur	Yes No
Hemophilia	Yes No	Hepatitis	Yes No
HIV/AIDS	Yes No	Hypertension	Yes No
Rheumatic Fever	Yes No	Stomach/liver/kidney problems	Yes No
Tuberculosis	Yes No		

*Please explain any medical problems that your child has: _____

_____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform this office of any changes in my child's medical status. I also authorize this dental staff to perform the necessary dental services my child may need. I also authorize Dr. Bancroft to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Dr. Bancroft otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services.

I agree to be responsible for payment of all services rendered on my behalf or dependents.

_____ _____

Signature of parent or guardian Date