Welcome

Tammy R. Severt, D.D.S., P.A.

www.severtsmiles.com

Date:_____

Please Tell Us About Your Child

Name:_____
Last First Middle

My child prefers to be addressed as _____

Gender: ☐ Male ☐ Female

Date of Birth:_____ Age:_____

School:_____Grade:_____

Home Address:_____
Street Apt/Condo #

_____
City State Zip

Home Telephone: _____Area Code:_____

E-mail address:_____

Hobbies/Interests_____

Siblings(with ages):_____

Other family members we have seen:

_____

General Dentist:_____

Whom May We Thank for Referring You?

_____

Who is Accompanying Your Child Today?

_____

Parents' Marital Status

___Single ___Married ___Divorced __Widowed __Separated

Mother's Information

Name:_____Birth Date:_____

Address:_____

_____

Home Telephone:_____

E-mail address:_____

SS#:_____

Employer:_____

Position/Occupation:_____

Work Telephone:_____ext:_____

Cell Phone:_____Area Code:_____

Does mother have legal custody of this child?___Yes____No

Father's Information

Name:_____Birth Date:_____

Address:_____

_____

Home Telephone:_____

E-mail address:_____

SS#: _____

Employer:_____

Position/Occupation:_____

Work Telephone:_____ext:_____

Cell Phone:_____Area Code:_____

Does father have legal custody of this child?____Yes____No

Medical History

Physician's Name:_____

Date of Last Visit:_____

Current Health is: ___Good ___Fair___Poor

Is your child taking any medication (include over-the -counter)? _____yes _____no

Please list each drug:_____

Does your child have a history of any of the following? (please circle):

Abnormal Bleeding	Blood Disorders	Epilepsy/Seizures	Mitral Valve Prolapse	Sinus Problems
Anemia	Blood Transfusions	Heart Disorders	Psychiatric Problems	Surgery
Acquired Immune Disorders	Cancer	Hospitalization	Radiation Treatment	Tuberculosis
Arthritis	Diabetes	Kidney Disorders	Rheumatic Fever	Ulcers/Colitis
Artificial Joints or Valves	Difficulty Breathing	Lung Disorders	Scarlet Fever	Vision/Hearing
Asthma	Drug/Alcohol Abuse	Migraines	Seasonal Allergies	

Other medical problems:_____

Please explain any circled responses:_____

Have adenoids and/or tonsils been removed? [ ] yes [ ] no If so, when?_____

In order to gauge growth, has puberty begun? [ ] yes [ ] no Girls: Has menstruation begun? [ ] yes [ ] no

Is your child *allergic* to any of the following? (please circle)

Anesthetics	Aspirin	Amoxicillin	Codeine	Cyclosporins	Erythromycin
Latex	Metal	Penicillin	Sulfa drugs	Tetracycline	Other

Please list any other drug or materials your child may be allergic to: _____

(over, please)

Dental History:

What are your main concerns regarding your child's teeth which you hope to address with orthodontic treatment? (i.e., appearance, function, crowding, etc.) _____

	YES	NO
Does your child see the dentist regularly (every six months)?	[ ]	[ ]
Have you ever been told that your child requires antibiotics before dental treatment?	[ ]	[ ]
Has your child ever had a serious/difficult problem associated with any previous dental work?	[ ]	[ ]
If yes, please explain:_____		
Does your child have any missing or extra permanent teeth?	[ ]	[ ]
Has your child ever had an injury to the face, mouth, or teeth?	[ ]	[ ]
If yes, please explain:_____		
Has your child ever had jaw-joint (TMJ) pain or discomfort?	[ ]	[ ]
If yes, please explain:_____		
Has your child been seen by an orthodontist before?	[ ]	[ ]
Has your child had orthodontic treatment before?	[ ]	[ ]

Person Responsible for Account:

Name: _____ Relationship to Patient:_____
Billing address: _____
Home Telephone:_____ Cell Telephone:_____
Employer:_____ Work Telephone:_____ext._____
SS#:_____

In the event of an emergency, is there someone not living in your household that we can contact:
Name:_____ Relationship to Patient:_____
Home Telephone:_____ Work Telephone:_____ext._____
Cell phone:_____

The information I have provided on this form is correct and true to the best of my knowledge. I understand that this information 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 authorize the doctor(s) and staff to perform any necessary dental procedures during diagnosis and treatment with my informed consent.

_____ _____
Signature Date

I understand that this office reserves the right to verify the credit status of potential responsible parties prior to determining a payment plan for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting agencies.

_____ _____
Signature Date