MINGA ORTHODONTICS
smile more.

This patient is a ☐ Kid ☐ Teen

Date _____

1 Patient Information

Tell us about your child:

Name _____ ☐ M ☐ F

Birthdate ____ / ____ / ____ Age _____ SS # _____

School _____ Grade _____

Hobbies / Sports _____

Musical Instruments Played _____

Child's Home Phone (____) _____

Child's Home Address _____
STREET APT #

_____
CITY STATE ZIP

Parent's E-mail address _____

2 Responsible Party Information

Who is accompanying your child today?

Name _____

Relation to Patient _____

Do you have legal custody of this child? ☐ Y ☐ N

If divorce is involved, who is the custodial parent?

_____

May patient information be released to non-custodial parent? ☐ Y ☐ N

Whom may we thank for referring you? _____

Other family members seen by us:

_____

Parent's Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

3 Parental Information

☐ Mother ☐ Stepmother ☐ Guardian

Name _____

Birthdate ____ / ____ / ____ Age _____ SS # _____

Home Phone (____) _____ Work Phone (____) _____

Employer _____

Occupation _____ Years Employed ____

☐ Father ☐ Stepfather ☐ Guardian

Name _____

Birthdate ____ / ____ / ____ Age _____ SS # _____

Home Phone (____) _____ Work Phone (____) _____

Employer _____

Occupation _____ Years Employed ____

4 Person Responsible for Account

Name _____ SS # _____

Relation to Patient _____

Home Phone (____) _____ Work Phone (____) _____

Employer _____

Billing Address _____
STREET APT #

_____
CITY STATE ZIP

Who is responsible for making appointments?

Name _____

Home Phone (____) _____ Work Phone (____) _____

5 Patient Orthodontic Insurance

PRIMARY INSURANCE

Orthodontic Coverage ☐ Y ☐ N Dental Coverage ☐ Y ☐ N

Insurance Co. Name _____

Insurance Co. Address _____
STREET SUITE #

_____
CITY STATE ZIP

Insurance Co. Phone (____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Policy Owner's Relation to Patient _____

Policy Owner's Birthdate ____ / ____ / ____ ID # _____

Policy Owner's Employer _____

Employer Address _____
STREET SUITE #

_____
CITY STATE ZIP

SECONDARY INSURANCE

Orthodontic Coverage ☐ Y ☐ N Dental Coverage ☐ Y ☐ N

Insurance Co. Name _____

Insurance Co. Address _____
STREET SUITE #

_____
CITY STATE ZIP

Insurance Co. Phone (____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Policy Owner's Relation to Patient _____

Policy Owner's Birthdate ____ / ____ / ____ ID # _____

Policy Owner's Employer _____

Employer Address _____
STREET APT #

_____
CITY STATE ZIP

Form is continued on back

6 Emergency Contact Information

In the event of an emergency, whom should we contact?

Name _____

Relation to Patient _____ Phone (_____) _____

Address _____
STREET APT #

_____
CITY STATE ZIP

7 Patient Dental History

Child's General Dentist _____

☐ Present ☐ Previous Date of last visit _____ / _____ / _____

Has your child ever had injury to his / her: ☐ Mouth ☐ Teeth ☐ Chin

Have adenoids or tonsils been removed? ☐ Y ☐ N

Does your child have any missing or extra permanent teeth? ☐ Y ☐ N

Has your child ever experienced any pain / discomfort in the jaw (TMJ / TMD)? ☐ Y ☐ N

Does your child brush his / her teeth daily? ☐ Y ☐ N

Does your child floss his / her teeth daily? ☐ Y ☐ N

Has your child ever experienced any of the following?

Y	N	Clenching /Grinding Teeth	Y	N	Nursing / Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

Has your child ever been evaluated for orthodontic treatment? ☐ Y ☐ N

What would you like orthodontics to accomplish? _____

_____

_____

8 Patient Medical History

Child's Physician _____

☐ Present ☐ Previous Date of last visit _____ / _____ / _____

Is your child under the care of a physician? ☐ Y ☐ N

Has puberty begun? ☐ Y ☐ N

GIRLS: has menstruation begun? ☐ Y ☐ N

Describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Has your child ever taken Phen-Fen? (Redux or Pondimin) ☐ Y ☐ N

If yes, when? _____

Please list all drugs your child is currently taking _____

_____

Please list all drugs / things your child is allergic to _____

_____

Has the patient ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Convulsions / Epilepsy
Y	N	ADD / ADHD	Y	N	Diabetes
Y	N	Allergies to Any Drugs	Y	N	Handicaps / Disabilities
Y	N	Allergies to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergy to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones / Joints	Y	N	HIV+ / AIDS
Y	N	Artificial Valves	Y	N	Kidney / Liver Problems
Y	N	Asthma	Y	N	Lupus
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Tuberculosis (TB)

Please discuss any medical problems your child has had _____

_____

_____

Thank you for filling out this form!

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

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit treatment frees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____ _____
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 and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

The parent or guardian who accompanies the child is responsible for payment.
Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.