HOOD & CARR
ORTHODONTICS

WELCOME

2755 Esplanade, Chico, CA 95973 • Phone: (530) 343-7021

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

Today's Date _____

1 TELL US ABOUT YOUR CHILD

Name _____

Preferred Name _____ ❑ M ❑ F ❑ N

Birthdate ___/___/___ Age___ SS# ___-___-_____

Address _____

City _____ State _____ Zip _____

Home Phone # _____

School _____ Grade _____

Hobbies / Sports _____

2 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name _____ Relation _____

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

List brothers/sisters and ages: _____

General Dentist: _____

Last Visit Date: _____

Parents' Marital Status: ❑ Single ❑ Widowed ❑ Married ❑ Divorced

3a PARENT INFORMATION

❑ MOTHER'S INFORMATION ❑ Step Mother ❑ Guardian

Name _____

Address _____

Home # _____ Work # _____

Cell # _____ Birthdate ___/___/___

Employer _____

❑ FATHER'S INFORMATION ❑ Step Father ❑ Guardian

Name _____

Address _____

Home # _____ Work # _____

Cell # _____ Birthdate ___/___/___

Employer _____

3b PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Billing Address _____

City _____ State _____ Zip _____

Home # _____ DL # _____

Email _____

Employer _____

Work # _____ Ext _____ SS # _____

4 PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

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

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birth Date _____ SS # _____

Policy Owner's Employer _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

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

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birth Date _____ SS # _____

Policy Owner's Employer _____

Continued on Back

5 REASON FOR TREATMENT

What are the main concerns that you would like orthodontics to address? _____

_____

_____

_____

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

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

List any musical instruments played: _____

_____

Have adenoids or tonsils been removed? ❑ Yes ❑ No

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

Has your child ever had any pain or 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 describe your child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list other medical condition(s) that they have ever had:

_____

_____

Please list ALL drugs OR materials that they are allergic to:

_____

_____

_____

_____

_____

_____

6 MEDICAL / DENTAL HISTORY

Has your doctor told you that your child requires antibiotics before dental treatment? ❑ Yes ❑ No

Is your child currently in pain? ❑ Yes ❑ No

Have they ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

Abnormal Bleeding?	❑ Yes ❑ No	Diabetes?	❑ Yes ❑ No
Allergy to Any Drugs?	❑ Yes ❑ No	Handicaps / Disabilities?	❑ Yes ❑ No
Allergy to Latex / Metals?	❑ Yes ❑ No	Hearing Impairment?	❑ Yes ❑ No
Allergy to Any Plastics?	❑ Yes ❑ No	Heart Murmur?	❑ Yes ❑ No
Any Hospital Stays?	❑ Yes ❑ No	Hemophilia?	❑ Yes ❑ No
Any Operations?	❑ Yes ❑ No	Hepatitis?	❑ Yes ❑ No
Asthma?	❑ Yes ❑ No	HIV+ / AIDS?	❑ Yes ❑ No
Cancer?	❑ Yes ❑ No	Kidney / Liver Problems?	❑ Yes ❑ No
Congenital Heart Defect?	❑ Yes ❑ No	Rheumatic / Scarlet Fever?	❑ Yes ❑ No
Convulsions / Epilepsy?	❑ Yes ❑ No	Tuberculosis (TB)?	❑ Yes ❑ No

Please discuss any medical problems that your child has had:

_____

_____

_____

7 DISCLAIMER

I understand that information I have given today is correct to the best of my knowledge. I also understand 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. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. 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 Date

THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT. PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS HAVE BEEN APPROVED.

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

❑ Please check here if you would like a copy of your child's HIPAA privacy policy.

OFFICE USE ONLY

I have verbally reviewed the medical / dental information above with the patient named herein: Initials _____ Date _____

Doctor's comments: _____

_____

_____

_____