MITCHELL & BOYER ORTHODONTISTS

Welcome To Our Office!

Robert D. Mitchell DDS MS & Ryan A. Boyer DDS MSD

Specialists in Orthodontics

Date _____

PATIENT INFORMATION

Name: _____ _____ Home Phone #: _____
First Middle Last Nickname

Address: _____ Email: _____ Birthday: _____

City: _____ State: _____ Zip: _____ Age: _____ Sex: ☐ M ☐ F

Referred By: _____ School: _____ Grade: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Who does child reside with? ___ Mom ___ Dad ___ Both ___ Other _____

Parent's Marital Status: __ Single ___ Widowed ___ Married ___ Divorced ___ Separated

PARENTS INFORMATION

FATHER ☐ Step ☐ Guardian

Name: _____

Father's Address Same As Child's: ☐ yes ☐ no

Other Address: _____

Home #: _____ Work #: _____

Employer: _____ Cell: _____

Email: _____

MOTHER ☐ Step ☐ Guardian

Name: _____

Mother's Address Same As Child's: ☐ yes ☐ no

Other Address: _____

Home #: _____ Work #: _____

Employer: _____ Cell: _____

Email: _____

MEDICAL INFORMATION

Child's Physician: _____ Phone #: _____ Date of Last Visit: _____

	YES	NO
Is Patient Under the Care of a Physician:		
Is the Patient in Good Health:		
ADD/ADHD:		
Any Hospital Stays/Operations:		
Any Heart Disease/Defects:		
H.I.V. Positive/AIDS:		
Artificial Bones, Joints/Valves:		
Cancer:		
Any High or Low Blood Pressure:		
A History of Fainting or Dizziness:		
Heart Murmur:		
Hemophilia:		
Hepatitis/Liver Problems:		
Sickle Cell Disease/Traits:		

	YES	NO
Handicaps/Disabilities/Hearing Impairment:		
Diabetes:		
Asthma or Hay Fever:		
Tuberculosis:		
Abnormal Bleeding:		
Any Seizure Disorder:		
Lupus:		
Kidney Problems:		
Rheumatic Fever/Scarlet Fever:		
Allergic to Latex / Metals:		
Has puberty begun:		
Has menstruation begun? (Girls):		
Patient ever taken Phen-Fen?(aka Redux or Pondium):		
If yes, when?		

Please discuss any medical problems that your child has had: _____

List Any Medications Currently Taking: _____

Is the Patient Allergic to Anything, if so what: _____

Any other disease, condition, or problem not listed above that we should know about: _____

DENTAL HISTORY

Child's Dentist: _____ Phone #: _____ Date of Last Visit: _____

	YES	NO
Has the Patient Been Evaluated or had Orthodontic Treatment Before:		
Has the Patient Seen a General Dentist in the Last Year:		
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:		
Frequent Headaches:		
Are You Aware of Any "Gum" Problems:		
Have the Patient's Tonsils or Adenoids Been Removed:		
Know of Any Missing or Extra Permanent Teeth:		
Pain/Clicking/Popping in Jaw Joint (TMD/ TMJ):		

	YES	NO
Brush & Floss Teeth Daily:		
Thumb/Finger Sucking:		
Mouth Breather:		
Finger Nail Biting:		
Tongue Thrusting:		
Clench/Grind Teeth:		
Speech Problems:		
Nursing/Bottle:		

In Your Own Words What is the Orthodontic Problem: _____

_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

_____

City State Zip

Home Address if different: _____

_____

Home/ Cell #: _____ DL #: _____

Employer: _____ Wk #:_____

SS#: _____ Birthdate: _____

PRIMARY INSURANCE

Dental Coverage? ___ Yes ___ No Ortho Coverage? ___ Yes ___ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group/ Policy #: _____

Policy Owner's Name: _____ Relation to Patient: _____

Policy Owner's Birth Date: ___/___/___ ID or SS#: _____

Policy Owner's Employer: _____

SECONDARY INSURANCE

Dental Coverage? ___ Yes ___ No Ortho Coverage? ___ Yes ___ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group/ Policy #: _____

Policy Owner's Name: _____ Relation to Patient: _____

Policy Owner's Birth Date: ___/___/___ ID or SS#: _____

Policy Owner's Employer: _____

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 authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of parent or guardian Date

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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.

_____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.
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

******* Please note that some longer procedures are only done in the mornings during school hours *******

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Member American Association of Orthodontists