Family Orthodontics at KidZdent

The smile you want from the people you trust

Consult Form

Today's Date _____

Patient's Last Name _____ **First** _____ **MI** _____

DOB: _____ **Age:** _____ **Sex:** _____ **"I Prefer to be called** _____**"**

Home Ph. #: _____ **Cell Ph. #:** _____ **Work Ph. #:** _____

Email Address/es: _____

Best Method for Appt. Confirmations (circle): EMAIL Home Ph. Cell Ph. Work Ph. Cell Text

Patient's Full Address: _____

Legal/ Custodial Parent(s) or Guardian(s): _____

Does Patient Live with Both Parents? Y/N : _____

Other Family Members Treated Here: _____

Person Financially Responsible for this Patient Account: _____

Address of Person Financially Responsible: _____

Does Patient have Insurance Coverage for Orthodontic Treatment? _____

PRIMARY INSURANCE

Name of Policy Holder: _____ **Employer:** _____

Insurance Co. Name & Address: _____

SSN/ ID#: _____ **DOB:** _____ **Group #:** _____

SECONDARY INSURANCE

Name of Policy Holder: _____ **Employer:** _____

Insurance Co. Name & Address: _____

SSN/ ID#: _____ **DOB:** _____ **Group #:** _____

Dentist Name: _____ **Town:** _____ **Ph. #:** _____

Date Last Seen by Dentist and Reason for Visit: _____

Do you have any dental treatment that needs to be done? _____

Tell us a little bit about the Patient…

- **What school/ grade does Patient attend?** _____ **Hobbies/ Sports?:** _____
- **What concerns you most about their smile?** _____
- **Are there other family members with the same condition?** _____
- **What types of braces are you interested in? Traditional ___ Clear ___ Invisalign ___**
- **Is there a target date you expect treatment to be completed by?** _____

Dental History Section (Answer/ Explain):

- **Has Patient had any accidents or trauma to their teeth/ face?** _____
- **Any teeth removed?** _____ **Any teeth Missing?** _____
- **Any dental conditions or problems that we should be aware of?** _____

Medical History Section (Answer Yes or No. If Yes, please explain):

Please check ALL conditions that apply to the patient:

	Y	N		Y	N		Y	N
Latex Allergy			Heart Ailments			Thyroid Disorders		
ASD/ Autism			Rheumatic Fever			Ulcer or Colitis		
Extreme Nervousness or Apprehension			Epilepsy or Seizures			Malignancies or Leukemia		
Developmentally Delayed			Heart Murmur			Chicken Pox		
Cerebral Palsy			Sinus Ailments			Mononucleosis		
Hyperactivity/ ADHD			Tonsilitis			Hearing Ailments		
Learning Disability			Tuberculosis			Eye Disorders		
Psychiatric Care/ Emotional Ailments			Kidney Ailments			Physical Handicaps		
Asthma or Other Respiratory Ailments			Diabetes			Excessive Bleeding		
Liver Ailments, Jaundice or Hepatitis			AIDS/ HIV +			Anemia or Blood Ailments		

Allergies/Explanations/ Other Medical Issues:

List all medications, vitamins, supplements, or herbal medications being taken:

_____

Physician's Name & Town: _____

Date & Reason Last Seen by Physician: _____

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KidZdent follows Federal and State law by complying with HIPAA standards. Our Notice of Privacy Practices took effect on April 15, 2003 and is available to you upon your request.

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I certify that I have read and understood the above. I understand that the information that I have given is correct to the best of my knowledge. I will not hold **KidZdent** or any member of the staff responsible for any errors or omissions I may have made in the completion of this form. I also authorize the Doctor's and staff of **KidZdent** to perform the necessary dental services that they have explained me.

Signature of Parent/ Legal Guardian: _____ **Date:** _____