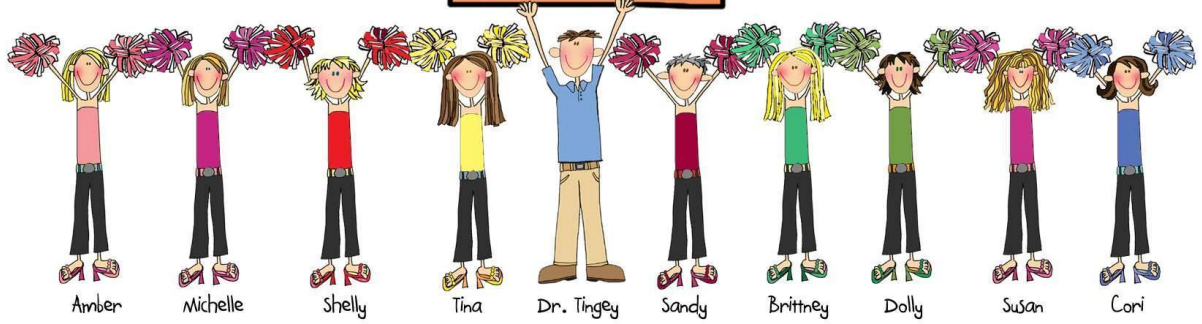




TINGEY Orthodontics

WELCOME TO TINGEY ORTHODONTICS

Our Team



PATIENT INFORMATION

NAME _____ DATE _____

NICKNAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTH DATE _____ AGE _____ M F

HOME PHONE NUMBER _____

EMAIL _____

STUDENT/SCHOOL _____

FAVORITE SPORTS OR HOBBIES _____

INCASE OF AN EMERGENCY CONTACT _____

PHONE _____ RELATION _____

GENERAL DENTIST _____

DENTAL INSURANCE YES OR NO

PRIMARY INSURANCE COMPANY _____

INSURED NAME _____

SOCIAL SECURITY # _____

EMPLOYER _____

SECONDARY INSURANCE COMPANY _____

INSURED NAME _____

SOCIAL SECURITY # _____

EMPLOYER _____

DO YOU HAVE A FLEX PLAN THROUGH WORK Yes No

MEDICAL HISTORY

YES NO HEART MURMUR

YES NO ASTHMA

YES NO RHEUMATIC FEVER

YES NO TUBERCULOSIS

YES NO PROLONGED BLEEDING

YES NO CANCER

YES NO ANEMIA

YES NO GROWTH DISORDERS

YES NO KIDNEY DISEASE

YES NO DISABILITIES

YES NO LIVER DISEASE

YES NO EMOTIONAL PROBLEMS

YES NO DIABETES

YES NO FEVER BLISTERS

YES NO HEPATITIS

YES NO ALLERGIES TO LATEX/METAL

YES NO EPILEPSY

YES NO ALLERGIES TO MEDICATION _____

YES NO FAINTING

HAVE TONSILS OR ADENOIDS BEEN REMOVED? YES NO

ANY HEALTH ISSUES WE SHOULD KNOW ABOUT? YES NO

REFERRAL

WHO MAY WE THANK FOR REFERRING YOU?

- DENTIST _____
- FRIEND _____
- YELLOW PAGES _____
- INTERNET _____
- OTHER _____

PARENT INFORMATION

MOTHER'S INFORMATION

NAME _____ DOB _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HM PHONE _____ CELL PHONE _____

EMPLOYER _____ PHONE _____

FATHER'S INFORMATION

NAME _____ DOB _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HM PHONE _____ CELL PHONE _____

EMPLOYER _____ PHONE _____

THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT.

GROWTH INFORMATION: BECAUSE GROWTH CAN BE AN IMPORTANT FACTOR IN ORTHODONTIC TREATMENT PLANNING, YOUR ANSWERS TO THE FOLLOWING ARE NEEDED TO AID IN OUR SELECTION OF TREATMENT ALTERNATIVES:

HAS YOUR CHILD REACHED PUBERTY YET? Y N

GIRLS: HAS SHE STARTED HER CYCLE? Y N

IF YES WHEN? _____

IF YES BOYS: HAS HIS VOICE CHANGED? Y N

WHEN? _____

FATHER'S HEIGHT _____ MOTHER'S HEIGHT _____

PLEASE INDICATE HISTORY OF:

Y N THUMB/FINGER SUCKING

Y N JAW JOINT PROBLEMS

Y N MOUTH BREATHING

Y N FREQUENT HEADACHES

Y N TONGUE THRUST

Y N SPEECH PROBLEMS

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

I CERTIFY THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS COMPLETE AND ACCURATE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____