Child Information Form

WELCOME
To assist us in providing the most complete service, please provide the following information and health history.

Lake Norman
Orthodontics
WWW.LKNORTHO.COM (https://lknortho.com/)

Date: ____________________

PERSONAL INFORMATION

Name: ______________ (FIRST) ______________ (MIDDLE) ______________ (LAST) Nickname: ______________

Sex: ________ Age: ________ Date of birth: ____________ School: ______________ Grade: ________

Brothers/Sisters (Name and Age): ________________________________

Dentist: ____________________ Physician: ____________________

Referred by: ________________________________

Mother

Name: ____________________

Address: ____________________

City: ________ State: ________ ZIP: ________

Home Phone: ____________________

Mobile Phone: ____________________

Employedby: ____________________

Work Phone: ____________________

Policy Owner's Birthdate: ____________ SS#: ________

Marital Status: ____________________

Parent's email address: ____________________

Father

Name: ____________________

Address: ____________________
(if different)

City: ________ State: ________ ZIP: ________

Home Phone: ____________________

Mobile Phone: ____________________

Employedby: ____________________

Work Phone: ____________________

Policy Owner's Birthdate: ____________ SS#: ________

Marital Status: ____________________

Parent's email address: ____________________

Person Responsible For Account: ________________________________

PRIMARY DENTAL INSURANCE ONLY

Ortho coverage? Yes ○ No ○ If "Yes" complete below

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

City: ________ State: ________ ZIP: ________

Insurance Co. Phone #: ____________________

ID/Policy #: ____________________

Policy Owner's Name: ____________________

Relationship to Patient: ____________________

Policy Owner's Birthdate: ____________ SS#: ________

Policy Owner's Employer: ____________________

SECONDARY DENTAL INSURANCE ONLY

Ortho coverage? Yes ○ No ○

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

City: ________ State: ________ ZIP: ________

Insurance Co. Phone #: ____________________

ID/Policy #: ____________________

Policy Owner's Name: ____________________

Relationship to Patient: ____________________

Policy Owner's Birthdate: ____________ SS#: ________

Policy Owner's Employer: ____________________

9615 Caldwell Commons Circle, Suite A
Cornelius, NC 28031
(P) 704.896.8452 (F) 704.896.8124

MEDICAL HISTORY

Please check box if patient has or has had:

- ☐ Positive HIV test
- ☐ Joint swelling
- ☐ Bone disorders
- ☐ Heart trouble
- ☐ Rheumatic fever
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Emotional problems
- ☐ Brain injury
- ☐ Kidney or liver involvement
- ☐ Puberty (Male/Female)
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Asthma
- ☐ Epilepsy
- ☐ Prolonged bleeding
- ☐ Faintness/Dizziness
- ☐ Tonsils removed
- ☐ Adenoids removed
- ☐ Sore throats
- ☐ Tonsillitis
- ☐ Earaches

List any other serious illnesses: ____________________

List any allergies: ____________________

List drugs or medications now being taken: ____________________

Is patient under physician's care presently? ____________________

Reason: ____________________

DENTAL HISTORY

Please check box if answer is yes:

- ☐ Any injuries to face, mouth, teeth? (circle)
- ☐ Thumb, finger, lip sucking? (circle)
- ☐ Mouth-breathing when asleep, awake? (circle)
- ☐ Sleep problems: snoring, restlessness, dark circle under the eyes (circle)
- ☐ More than average amount of decay?
- ☐ Any missing permanent teeth?
- ☐ Any extra permanent teeth?
- ☐ Any teeth removed by extraction?
- ☐ Is there any tongue-thrusting problem?
- ☐ Any speech problems?
- ☐ Any difficulty in swallowing or chewing?
- ☐ Any pain or clicking on opening mouth?
- ☐ Does patient visit dentist regularly?

Date of last dental visit: ____________________

☐ Has an orthodontist been consulted previously?

Reason: ____________________

____

Name of physician: ____________________

Approximately how much has patient grown in the last year? ____________________

Additional comments: ____________________

Please note any other factors the doctor should know about the patient's dental health:

____

What are your chief concerns regarding your child's orthodontic condition? (0verbite, crowding, etc.):

____

PATIENT AUTHORIZATION – PLEASE SIGN BELOW

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.

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

Date: ____________

Signature of parent or guardian:

I authorize the dental staff to perform the necessary dental servicesmy child may need.

Date: ____________

Signature of parent or guardian:

If this office accepts insurance, I understand that I am responsiblefor payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Date: ____________

Signature of parent or guardian:

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