Welcome to Dr. Sherick's Office

Thank you for completing this form and for providing this important information.
Print clearly and complete both sides. A signature is required.

Patient's Name: _____ Nickname: _____ ☐ Female ☐ Male
Date of Birth: ____/____/____ Age: _____ Names/ages of siblings: _____
Patient's school: _____ Grade: _____ Patient interests: _____
Child's home address: _____
Child's home phone number :(____) _____ Primary Family Email: _____

Who is accompanying your child today? Name: _____ Relation: _____
Does this person have legal custody of this child? Yes/No Is the child adopted? Yes/No
Whom may we thank for referring you? _____
Other family members seen by us: _____
Parent's marital status: Single Married Divorced Separated Widowed Partnered

Mother's Information:
Name: _____ Date of Birth: ____/____/____ Mother/Stepmother
Home Address: _____
How long at this address: _____
Previous address (if less than three years): _____
Employer: _____ Occupation: _____ Years of Employment: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone :(____) _____
Social Security Number: _____ Driver's License Number: _____

Father's Information:
Name: _____ Date of Birth: ____/____/____ Father/Stepfather
Home Address: _____
How long at this address: _____
Previous address (if less than three years): _____
Employer: _____ Occupation: _____ Years of Employment: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone :(____) _____
Social Security Number: _____ Driver's License Number: _____

Person(s) Financially Responsible for the Account:
Name(s): _____ Relation: _____
Billing Address: _____
Previous Address: _____
Employer: _____ Occupation: _____ Years of Employment: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone :(____) _____
Social Security Number: _____ Driver's License Number: _____

Person Responsible for making appointments: Name: _____ Relation: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone :(____) _____

Primary Dental Insurance **(<u>not Health Insurance</u>)**
Orthodontic Coverage/Benefit: Yes/No
Insurance Company Name and Address: _____
_____
Insurance Company Phone Number: (____) _____ Employer: _____
Policy Holder/Subscriber Name: _____ Date of Birth: ____/____/____
Relation to Patient: _____ Subscriber ID/SSN: _____ Group #: _____
Insurance card available: Yes/No

Secondary Dental Insurance **(<u>not Health Insurance</u>)**
Orthodontic Coverage/Benefit: Yes/No
Insurance Company Name and Address: _____
_____
Insurance Company Phone Number: (____) _____ Employer: _____
Policy Holder/Subscriber Name: _____ Date of Birth: ____/____/____
Relation to Patient: _____ Subscriber ID/SSN: _____ Group #: _____
Insurance card available: Yes/No

MEDICAL HISTORY

Name of Physician:_____ Current Medical Problems:_____

Has your child ever been diagnosed with any of the following diseases or medical conditions?

Abnormal or Excessive Bleeding	Y	N	Delayed development	Y	N	Nervous disorder	Y	N
ADD/ADHD	Y	N	Diabetes	Y	N	Pacemaker	Y	N
Allergies to Drugs	Y	N	Endocrine problems	Y	N	Pregnancy	Y	N
Allergies to Latex or Metals	Y	N	Emotional problems	Y	N	Currently pregnant	Y	N
Allergies to Plastics	Y	N	Fainting or dizziness	Y	N	Psychiatric treatment	Y	N
Any hospital stays	Y	N	Glaucoma	Y	N	Rheumatic/Scarlet fever	Y	N
Any surgeries	Y	N	Handicaps or disabilities	Y	N	Sinus trouble	Y	N
Artificial bones, joints, or valves	Y	N	Headaches (recurrent)	Y	N	Stomach ulcers	Y	N
Asthma	Y	N	Hearing impairment	Y	N	Stroke	Y	N
Bone disorders	Y	N	Heart disease	Y	N	Tonsillitis (recurrent)	Y	N
Cancer or malignancies	Y	N	Heart murmur	Y	N	Tuberculosis	Y	N
Congenital heart defect	Y	N	Hepatitis (A/B/C) (please circle one)	Y	N			
Convulsions, epilepsy or seizures	Y	N	High blood pressure	Y	N			
			HIV/AIDS	Y	N	Other_____		
			Kidney/liver problems	Y	N			

Please provide additional information if you answered yes to any of the above:_____

_____

_____

Please describe your child's current physical health: Good Fair Poor

List any medication your child is currently taking:_____

List all drug allergies or sensitivities (not previously mentioned):_____

Has your child ever taken any of the following? Fen-Phen Redux Pondimin Zometa Aredia Boniva Actonel Fosamax

If so, when? _____ Dosage:_____

Does the patient smoke?_____ Any additional not previously mentioned:_____

DENTAL HISTORY

Name of Dentist:_____ Office phone:_____ Date of last check-up:_____

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

Patient's attitude toward orthodontics:_____ Have you consulted another orthodontist? Yes/No When?_____

Does your child brush his/her teeth daily? Yes/No Does he/she floss daily? Yes/No

Has your child ever exhibited or been treated for any of the following?

Y	N	Injury to the face, mouth or jaws	Y	N	Tongue thrusting
Y	N	Removal of adenoids or tonsils	Y	N	Teeth grinding/clenching
Y	N	Extraction of teeth	Y	N	Speech therapy
Y	N	Mouth breathing/snoring	Y	N	Thumb/finger sucking
Y	N	Pain or clicking in jaw joints	Y	N	Lip biting
Y	N	Missing or extra permanent teeth	Y	N	Nail biting
Y	N	Previous orthodontic treatment			

EMERGENCY CONTACT-Friend or relative not residing with you

Name:_____ Phone:_____ Relation to patient:_____

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

_____

Signature Date

*This office will not be held responsible for any problems arising from information not disclosed.

I have authorized the Orthodontist to share this patient's treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit pertinent information to the insurance company for billing purposes only.

_____

Signature Date