SHLASH ORTHODONTICS

DALIA SHLASH DDS MPH

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TELL US ABOUT YOUR CHILD

Child's Name: _____

Gender:_____ Birth date: ____/____/_____ Age: ____

School: _____ Grade: ____

Hobbies: _____

_____

Child's Home Address: _____

_____

_____

Phone Number: _____

Siblings: _____

_____

Have they been treated in our office? Yes ____ No ___

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: _____

WHAT ARE YOUR MAIN CONCERNS?

_____

_____

_____

Has the child been seen by another orthodontist?

Yes ____ No ____

Have there been injuries to the face/jaw/mouth/teeth?

Yes ____ No ____

List any musical instruments played: _____

Does your child brush daily? Yes ____ No ____

Does your child floss daily? Yes ____ No ____

PATIENT MEDICAL HISTORY

Y N Tuberculosis
Y N Asthma
Y N Diabetes
Y N Hepatitis
Y N HIV or AIDS
Y N Rheumatic Fever
Y N Abnormal Bleeding
Y N Epilepsy
Y N Tonsils Removed
Y N Adenoids Removed
Y N Latex Allergy
Y N Allergies
Y N Heart Problems
Y N Emotional Problems
Y N Cancer
Y N Dialysis/Transplant/Hospitalization

If Yes, please describe: _____

_____

_____

_____

Physician Name: _____

List drug allergies: _____

List current medications: _____

_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y N Clenching/Grinding Teeth

Y N Lip Sucking/Biting

Y N Mouth Breather

Y N Nail Biting

Y N Speech Problems

Y N Thumb/Finger Sucking

Y N Tongue Thrust

MOTHER'S INFORMATION (OR GUARDIAN)

Name _____

Birth Date: _____/_____/_____

Work # _____

Home # _____

Cell Phone # _____

Email:_____

Address: _____

_____

Employer: _____

FATHER'S INFORMATION (OR GUARDIAN)

Name _____

Birth Date: _____/_____/_____

Work # _____

Home # _____

Cell Phone # _____

Email:_____

Address: _____

_____

Employer: _____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes ____ No ____

Insurance Co. Name: _____

Address: _____

_____

Ins Phone #: _____

Group #: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Holder's Birth Date: _____/_____/_____

Insurance ID # or SS #: _____

Policy Holder's Employer: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes ____ No ____

Insurance Co. Name: _____

Address: _____

_____

Ins Phone #: _____

Group #: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Holder's Birth Date: _____/_____/_____

Insurance ID # or SS #: _____

Policy Holder's Employer: _____

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____