WELCOME

To the office of Dr. John J. Brady

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell us about your Child

Today's Date: ________________________

Child's Name: ______________________________________
Last First MI

Nickname: ________________________ ❑ Male ❑ Female

Birth date: _______/_______/_______ Age: _____________

School: ______________________________________

Hobbies / Sports: ______________________________

Home Address: ______________________________

____
City State Zip

Child's Home Phone Number ____________________

List Brothers/Sisters with birth date

______________________________ _______________

______________________________ _______________

______________________________ _______________

Family Dentist: ______________________________

Last Visit Date: ________________________________

Other Family Members seen by us: ____________________

____

Whom may we thank for telling you about our office?

____

Primary Orthodontic Insurance

Orthodontic Coverage? ❑Yes ❑ No

Insurance Co. Name: ____________________________

Insurance Co. Phone # ____________________________

Insured's Name: ________________________________

Parents Information

MOTHER'S INFORMATION

Mother's Name: ________________________________

Address: ______________________________________

____

Home # _________________ Wk. # __________________

Cell # ___________________

E-mail address: ________________________________

Occupation: ____________________________________

Employer: ______________________________________

How long there? ________ S.S. # _____ - ____ - _______

FATHER'S INFORMATION

Father's Name: ________________________________

Address: ______________________________________

____

Home # _________________ Wk. # __________________

Cell # ___________________

E-mail address: ________________________________

Occupation: ____________________________________

Employer: ______________________________________

How long there? ________ S.S. # _____ - ____ - _______

Person Responsible for Account

Name: ____

Billing Address: _________________________________

____

Wk. # ___________________ Home # _________________

Relationship: _______________ SS# ______/____/_______

Employer: ______________________________________

How long there? _______________________

What are the main concerns that you would like orthodontics to accomplish?

____

____

Has your child ever been evaluated or had orthodontic treatment before? ❑ Yes ❑ No

Have there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

List any musical instruments played: ____________________

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ?TMD) ❑ **Yes** ❑ **No**

Does your child brush his/her teeth daily ❑ Yes ❑ No

Floss his/her teeth daily? ❑ Yes ❑ No

Child's Physician: ________________________________

Phone #: ________________ Date of last visit: ____________

Is your child currently under the care of a physician? ❑ Yes ❑ No

Type of treatment is dependant on growth and development, therefore:

Has puberty begun? ❑ Yes ❑ No

Has menstruation begun? (Girls) ❑ Yes ❑ No

Please describe your child's current physical health:

❑ **Good** ❑ **Fair** ❑ **Poor**

Please list all the drugs that your child is currently taking:

____

Please list all the drugs that your child is allergic to:

____

____

Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Allergies to Latex / Metals
Y N Allergies to Plastics
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Diabetes
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+ / AIDS
Y N Kidney / Liver Problems
Y N Rheumatic / Scarlet Fever
Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

____

____

____

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 Nursing Bottle Habits
Y N Speech Problems
Y N Thumb / Finger Sucking
Y N Nail Biting
Y N Tongue Thrust

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC & ADA.

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.

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

____
Signature of parent or guardian Date

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

____
Signature of parent or guardian Date