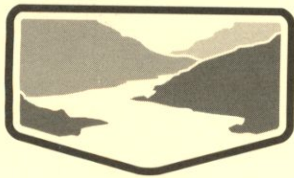

BICKLER ORTHODONTICS

Child Orthodontic Acquaintance Card
(please print)

Patient's Name ______________________ Date __________ Birthdate __________

Nickname ______________________ Sex ______ Age ______

Address ____

City ______________ ZIP. __________ School ______________ Grade __________

Patient Email ______________________ Phone ______________ Type __________

Dentist ______________________ Phone2 ______________ Type __________

Prefered Contact Method? ❑ Phone ❑ Text ❑ Email

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single

Relation:	Mother	Father
Name:		
Person Responsible for Account:		
Address (if different from above):		
Email Address:		
Phone (if different from above):	❑Mobile	❑Mobile
Social Security Number:		
Birth Date:		
Employer's Name:		
Business Address:		
Business Phone:		
Occupation:		

If other than parent:

Name: ______________ Address: ______________________ Phone: ______________

Does your insurance cover orthodontics? YES ❑ NO ❑

DENTAL INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. For your convenience, we will gladly submit insurance claims pertaining to any charge for care in our office.

Policy holder's name ______________________ Soc. Sec. No. ______________
LAST FIRST MIDDLE

Policy holder's Date of Birth ______________________

Insurance Co. ______________ Group No. __________ Union Local No. __________

Insurance Co. Address ______________________ Insurance Co. Phone ______________

Policy Holder's Employer ______________________

Do you have dual coverage? ❑ YES ❑ NO if yes:

Policy holder's name ______________________ Soc. Sec. No. ______________

Insurance Co. ______________ Group No. __________ Union Local No. __________

Insurance Co. Address ______________________ Insurance Co. Phone ______________

Policy Holder's Employer ______________________

Rev. 9/15

DENTAL HISTORY

Dentist: ______________________

Date of the last dental exam: ______________

Has the patient been told of:

Unfinished Dental Care	YES ❑	NO ❑
Thumb/finger sucking	YES ❑	NO ❑
Tongue thrusting	YES ❑	NO ❑
Mouth breathing	YES ❑	NO ❑
Teeth grinding/clenching	YES ❑	NO ❑
Missing or extra permanent teeth	YES ❑	NO ❑
Ear infections	YES ❑	NO ❑
Gum Disease	YES ❑	NO ❑
Fear of treatment	YES ❑	NO ❑

Has your child ever been injured in the mouth or face?
YES ❑ NO ❑

Have tonsils and adenoids been removed?
YES ❑ NO ❑

Have any primary or permanent teeth been extracted?
YES ❑ NO ❑

Comments: ______________________

Why did you seek this orthodontic consultation? ________

Who referred you? ______________

Have you ever been examined by an orthodontist before?
❑ YES ❑ NO

Is the patient interested in having orthodontic treatment?
❑ YES ❑ NO

Has any other family member had orthodontic treatment?
❑ YES ❑ NO

Relatives or friends treated here?
❑ YES ❑ NO

Who?______________

MEDICAL HISTORY

Physician: ______________________

Is the patient in good health? YES ❑ NO ❑

Has the patient seen a physician in the last 2 years?
YES ❑ NO ❑

What was the reason for the visit? ______________

List any drugs or medications now being taken?

List any allergies or sensitivity? ______________

Does the patient wear contact lenses? YES ❑ NO ❑

Does your child take any medication for bone density?
YES ❑ NO ❑

Check any of the following for which the patient has been treated:

Diabetes	**YES ❑**	**NO ❑**
Hepatitis	**YES ❑**	**NO ❑**
Heart Trouble	**YES ❑**	**NO ❑**
Glaucoma	**YES ❑**	**NO ❑**
Rheumatic Fever	**YES ❑**	**NO ❑**
High Blood Pressure	**YES ❑**	**NO ❑**
Bone Disorders	**YES ❑**	**NO ❑**
Prolonged Bleeding	**YES ❑**	**NO ❑**
Thyroid Disorders	**YES ❑**	**NO ❑**
Fainting/Dizziness	**YES ❑**	**NO ❑**
Tuberculosis	**YES ❑**	**NO ❑**
Epilepsy	**YES ❑**	**NO ❑**
Anemia	**YES ❑**	**NO ❑**
Asthma	**YES ❑**	**NO ❑**
Arthritis	**YES ❑**	**NO ❑**
Head & Neck Pain	**YES ❑**	**NO ❑**
Immunity Disorders	**YES ❑**	**NO ❑**
AIDS	**YES ❑**	**NO ❑**

Is there any other information that may be helpful for your treatment today ______________

EMERGENCY INFORMATION

Name of nearest relative not living with you ______________________

Phone ______________________ Relationship ______________

AUTHORIZATION RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. ***I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.***

______________________ Reviewed by: ______________

Signature Date