Keith Street, D.M.D.
Orthodontics
Dentofacial Orthopedics

We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

Thank You!

PATIENT INFORMATION

Patient Name _____ ❑ Male ❑ Female
Social Security # _____ Birth Date _____ Age _____
Home Address _____
City _____ State _____ Zip _____
Primary Phone # _____ ❑ home ❑ cell Ok to leave Message? ❑ Y ❑ N
Email _____
School _____ Grade _____
List any sports or extracurricular activities _____
Siblings (names and ages) _____

PARENT / GUARDIAN INFORMATION

Parent's Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Significant Other

❑ Mother ❑ Step-Mother ❑ Guardian ❑ Other Name _____
Social Security # _____ Birth Date _____ Driver License # _____
Address (if different than child's) _____
City _____ State _____ Zip _____
Phone # _____ ❑ home ❑ cell Secondary Phone # _____ ❑ home ❑ cell
Employer's Name _____ Occupation_____

❑ Father ❑ Step-Father ❑ Guardian ❑ Other Name _____
Social Security # _____ Birth Date _____ Driver License # _____
Address (if different than child's) _____
City _____ State _____ Zip _____
Phone # _____ ❑ home ❑ cell Secondary Phone # _____ ❑ home ❑ cell
Employer's Name _____ Occupation_____

EMERGENCY CONTACT

Emergency Contact Name (other than parent) _____
Phone # _____ Relation to child _____
Address _____
City _____ State _____ Zip _____

Person(s) OK to release appointment or medically related information to concerning child.
_____ Relation(s) _____

INSURANCE INFORMATION

Primary Insurance Company _____ Phone Number _____
Group # _____ Policy # _____ Member ID # _____
Policy Holder's Name _____ Relation _____
Policy Holder's Social Security # _____ Policy Holder's Birth Date _____
Employer _____ Work Phone # _____
Co-pay (if known) _____ Deductible (if known) _____

Secondary Insurance Company _____ Phone Number _____
Group # _____ Policy # _____ Member ID # _____
Policy Holder's Name _____ Relation _____
Policy Holder's Social Security # _____ Policy Holder's Birth Date _____
Employer _____ Work Phone # _____
Co-pay (if known) _____ Deductible (if known) _____

DENTAL HISTORY

General Dentist _____ Last Visit _____
How did you hear about our Practice?
❑ Ad ❑ Internet ❑ Family or Friend ❑ Physician ❑ Other
Name of person referring (if applicable) _____
What are the main concerns you would like orthodontics to accomplish?
_____
Has your child visited an orthodontist before? ❑ Y ❑ N
When? _____ Reason? _____
Have we treated any other family members? ❑ Y ❑ N Name _____
Have your child's tonsils or adenoids been removed? ❑ Y ❑ N
Has your child ever experienced jaw joint pain/discomfort (TMJ/TMD) ? ❑ Y ❑ N
Does your child have any missing or extra permanent teeth? ❑ Y ❑ N
Has your child ever had an injury to (*select all that apply*): ❑ Teeth ❑ Mouth ❑ Chin
Does your child have speech problems? ❑ Y ❑ N If so, explain _____
Does your child currently or has your child ever had any of the following habits
(*check all that apply*)

❑ Clenching/Grinding Teeth	❑ Mouth Breathing	❑ Thumb / Finger Sucking
❑ Lip Sucking/Biting	❑ Nail biting	❑ Chewing / Eating Problem

MEDICAL HISTORY

Is your child currently being treated by a physician? ❑ Y ❑ N Reason _____
Physician _____ Last Visit _____ Phone _____
Does your child have any allergies/sensitivities to medications or latex? ❑ Y ❑ N
If yes, please list.
_____
Is your child currently taking any prescription or over-the-counter medications? ❑ Y ❑ N
Please list, with dosage. _____
Has puberty and/or menstruation begun? ❑ Y ❑ N ❑ N/A

Has your child ever taken any of the group of drugs collectively referred to as “fen-phen?” These include combinations of lonimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)? ❑ Y ❑ N

Has your child had any serious illnesses or operations? If yes, describe:

_____

Has your child ever had a blood transfusion? ❑ Y ❑ N

If yes, give approximate dates: _____

Is your child pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check if your child has or has ever had any of the following:

❑ Anemia	❑ Cortisone Treatments	❑ Hepatitis	❑ Scarlet Fever
❑ Arthritis, Rheumatism	❑ Cough, Persistent	❑ High Blood Pressure	❑ Shortness of Breath
❑ Artificial Heart Valves	❑ Coughing Blood	❑ HIV/AIDS	❑ Skin Rash
❑ Artificial Joints	❑ Diabetes	❑ Jaw Pain	❑ Stroke
❑ Asthma	❑ Epilepsy	❑ Kidney Disease	❑ Swelling of Feet or Ankles
❑ Back Problems	❑ Fainting	❑ Liver Disease	❑ Thyroid Problems
❑ Blood Disease	❑ Glaucoma	❑ Mitral Valve Prolapse	❑ Tobacco Habit
❑ Cancer	❑ Headaches	❑ Pacemaker	❑ Tonsillitis
❑ Chemical Dependency	❑ Heart Murmur	❑ Radiation Treatment	❑ Tuberculosis
❑ Chemotherapy	❑ Heart Problems	❑ Respiratory Disease	❑ Ulcer
❑ Circulatory Problems	❑ Hemophilia	❑ Rheumatic Fever	❑ Venereal Disease

AUTHORIZATION

- I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child’s medical status.
- I hereby authorize the release of any information pertaining to my child’s medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.
- I understand that where appropriate, credit bureau reports may be obtained.

_____ _____

Patient Signature and/or Responsible Party Date