Polaris Orthodontic Center

CENTER FOR ADULT AND ADOLESCENT ORTHODONTIC TREATMENT

Amin Mason, DDS, MSD

New Patient Information (Child)

Patient's Name: ______________________

Today's Date: ______/______/________

Child's Information

Date of Birth: _______/____/__________Age:____________

Sex: ☐ Male ☐ Female

Address: ____

City: ___________________ State: ______ Zip: __________

Your relation to child:_______________________________

Responsible Party Information

Mother's Information

Name: ____

Address: ____

City: ____________________ State: ______Zip: _________

E-mail:____

Home Phone: _____________________________________

Cell Phone: ______________________________________

Employer: _______________________________________

Occupation: ______________________________________

Fathers Information

Name: ____

Address: ____

City: ____________________ State: ______ Zip: _________

E-mail:____

Home phone:______________________________________

Cell Phone: ______________________________________

Employer: _______________________________________

Occupation: ______________________________________

Other Information

How did you hear about us? (Please circle your answer)

Dentist referral Insurance referral Internet search

Mailer Drive-by

Friends/Family (specify who):_________________________

Other: ____

What is the Primary reason that your child is seeing an Orthodontist today? _______________________________

Has your child had Phase I orthodontic treatment previously?
☐Yes ☐No

Has your child seen an orthodontist previously? ☐Yes ☐No

Is your child transferring from another Orthodontist?
☐Yes ☐No Previous Orthodontist Name________________

Were you satisfied with previous orthodontic treatment of your child? ☐ Yes ☐ No ☐ NA
If No, please explain:_______________________________

What type/types of treatment options are you interested regarding your child?

☐Traditional Braces **☐Invisalign clear trays**
☐Clear braces **☐ Lingual/ Hidden braces**

For patients that participate in sports, we may recommend **Invisalign** to reduce the chance of sports related injuries. Does your Child have any hobbies or participate in any sports? ____

Insurance Information

Does your child have insurance? ☐ Yes ☐ NO

Primary Insurance

Members Name___________________________________

Member ID# (SS#): ______________________________

Date of Birth: _____/______/________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other

Other (please explain): ___________________________

Insurance Carrier: ________________________________

Insurance Phone #: _______________________________

Insurance address: _______________________________

City: ____________State ___________Zip_______________

Group, Plan or Policy #: ___________________________

Employer: ______________________________________

Secondary Insurance must be filed by the patient.

Patient Dental History

Dentist Name: ______________________________________
Address: ____
Phone: ____
Approximate date of last visit: Month______/Year_______
Were there any cavities or dental problems present?
☐ Yes ☐ No If yes, Please explain: _______________________
____

Has your child ever experienced any dental or facial trauma? (Examples include: Dental injuries, car accident, jaw or facial injuries related to sports or falling). ☐Yes ☐No
If yes, Please Explain:________________________________

How often does your child brush his/her teeth?__times a day

Does your child use a Waterpik water flosser? ☐ Yes ☐ No

Does your child have or have had any of the following habits:

___Thumb sucking ___ Mouth breathing
___Tongue thrusting ___Nail biting/chewing
___Smoking ___ Snoring

Does your child have or ever had a history of the following?

___Grinding/clenching ___Jaw popping
___Jaw/Joint clicking ___Ringing in ears
___Jaw/Joint soreness ___Excessive headaches

Patient Medical History

Does your child have a hyperactive gag reflex? ☐ Yes ☐ No

Has your child ever been advised to take antibiotics before dental treatment? ☐ Yes ☐ No

For Female Patients only:

Is there a possibility that your child may be pregnant?
☐ Yes ☐ No

Has your child started menstrual cycle? ☐ Yes ☐ No

Does your child have or have had a history of the following:
Please circle "Y" for yes or "N" for no.

Heart murmur	Y	N	Hepatitis	Y	N
Blood disease	Y	N	Herpes	Y	N
Anemia	Y	N	Epilepsy/Seizures	Y	N
Heart disease	Y	N	Tuberculosis	Y	N
HIV/AIDS	Y	N	Adenoids Removal	Y	N
Diabetes	Y	N	Endocrine problem	Y	N
Tonsillitis	Y	N	Prolonged bleeding	Y	N
Jaundice	Y	N	Bone disorder	Y	N
Asthma	**Y**	**N**	Rheumatic fever	Y	N
Mouth breathing	Y	N	Sinus Infections	Y	N
Chemotherapy	Y	N	Allergic reaction	Y	N
Surgeries	Y	N	Radiation	Y	N
Cancer	Y	N	Autism/Asperger	Y	N
Mental disorders	Y	N	Anxiety	Y	N
ADD/ADHD	**Y**	**N**	**Learning Disabilities**	**Y**	**N**

Please Explain: ______________________________________
____
____

Please list ALL medical conditions not list above:__________
____
____

Is your child currently taking **any** medications? ☐Yes ☐No
If Yes, Please list:
____
____
____

Is your child allergic to **any** medications, food or latex?
☐Yes ☐No Please list: _______________________________
____

Is your child under the care of a physician ☐Yes ☐ No
Name of Physician: __________________________________
Address: ____
Phone #: ____

X

Patient /Responsible party's Signature: DATE:

Doctor's Comments:____

Doctor's Signature: ______________________________________ **Date:** _______/_________/__________