Erhart Orthodontics, P.C.
MICHAEL ERHART DDS

Date: _____

PATIENT

First and last name: _____ Preferred greeting: _____

Date of birth: _____ Age: _____ Sex: □ Male □ Female

Home address: _____

Home phone: _____ Patient's cell phone: _____

PARENT/GUARDIAN

Custodial parent(s') name(s):_____

Patient lives with *(check all that apply)*: □ Mother □ Father □ Stepmother □ Stepfather □ Other _____

Father's full name: _____ Title: □ Mr. □ Dr. □ Other _____

Occupation: _____ Email address: _____

Address *(if different)*: _____

Home phone *(if different)*: _____ Cell phone: _____

Mother's full name: _____ Title: □ Mrs. □ Ms. □ Dr. □ Other _____

Occupation: _____ Email address: _____

Address *(if different)*: _____

Home phone *(if different)*: _____ Cell phone*:* _____

DENTIST

Patient's dentist: _____ City, State: _____

Last seen: _____ Reason: _____ Next appointment: _____

GENERAL INFORMATION

Who referred you to our office? _____

What concerns you about your child's teeth? _____

Any previous orthodontic treatment and/or consultations? _____

Have any other family members been treated at our office? Please name them: _____

Have parents or siblings ever had any of the following problems?

Under bite □ Yes □ No *Excessive overbite* □ Yes □ No *Unusual dental problems/missing teeth* □ Yes □ No

If yes, explain: _____

ALLERGIES

Does your child have **any** allergies? □ Yes □ No If yes, please explain: _____

For any food related allergies listed above, does adverse reaction occur with contact alone or only when ingested?

_____

Your answers are for our records only and are confidential.

MEDICAL HISTORY

Has your child ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Is your child taking any medications (including over the counter)? ☐ Yes ☐ No If yes, please list: _____

Does your child have any mouth habits (e.g., finger/thumb sucking, pacifier)? ☐ Yes ☐ No If yes, please explain: _____

Does your child have a history of any of the following?

Autism	☐ Yes ☐ No	Asperger's	☐ Yes ☐ No	Sensory processing disorder	☐ Yes ☐ No
Developmental delay	☐ Yes ☐ No	Speech delay	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Depression	☐ Yes ☐ No	ADD	☐ Yes ☐ No	Hearing loss	☐ Yes ☐ No
Down syndrome	☐ Yes ☐ No	ADHD	☐ Yes ☐ No	Eating disorder	☐ Yes ☐ No
Brain injury	☐ Yes ☐ No	Apraxia	☐ Yes ☐ No	Asthma	☐ Yes ☐ No

Now, or in the past, has your child had any of the following?

Birth defects/hereditary problems	☐ Yes ☐ No	Cancer, tumor, radiation/chemotherapy	☐ Yes ☐ No
Injuries to face, head or neck	☐ Yes ☐ No	Endocrine or thyroid problems	☐ Yes ☐ No
Arthritis or joint problems	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Immune system problems	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	Fainting spells	☐ Yes ☐ No
Frequent headaches/migraines	☐ Yes ☐ No	High/low blood pressure	☐ Yes ☐ No
Anemia/excessive bleeding/bruising	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No
Rheumatic heart disease	☐ Yes ☐ No	Skin disorder (other than common acne)	☐ Yes ☐ No
Frequent ear infections	☐ Yes ☐ No	Tonsil or adenoid condition	☐ Yes ☐ No
HIV or STD	☐ Yes ☐ No		

DENTAL HISTORY

Does your child have a history of any of the following?

Erupting teeth very early/late	☐ Yes ☐ No	Mouth breathing habit	☐ Yes ☐ No
Baby teeth removed that were not loose	☐ Yes ☐ No	Tooth grinding/ clenching	☐ Yes ☐ No
Permanent or extra teeth removed	☐ Yes ☐ No	Clicking/locking in jaw joints	☐ Yes ☐ No
Congenitally missing teeth	☐ Yes ☐ No	Soreness in jaw muscles	☐ Yes ☐ No
Chipped or injured teeth	☐ Yes ☐ No	Treatment for "TMJ" or "TMD"	☐ Yes ☐ No
Sensitive or sore teeth	☐ Yes ☐ No	Diagnosis of gum disease	☐ Yes ☐ No
Lost or broken filings	☐ Yes ☐ No	Root canals/pulpotomies	☐ Yes ☐ No
Jaw fractures	☐ Yes ☐ No	Frequent canker/cold sores	☐ Yes ☐ No

Is there any additional information we should know? If yes, please explain:

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. Furthermore, I understand that it is my responsibility to inform the office of any changes in medical status.

_____ _____

Signature of Parent/Guardian Date

HIPAA Acknowledgement

**You may refuse to sign this acknowledgement.*

**Notice of Privacy Practices is available on our website and at our front desk.*

I am the parent or legal guardian of _____ and have reviewed Erhart Orthodontics' Notice of Privacy Practices.

_____ _____

Signature of legal guardian **Date**

Disclosure Permission

I authorize Erhart Orthodontics to discuss health information with the following individuals:

_____ _____

Name **Relationship to patient**

_____ _____

Name **Relationship to patient**

_____ _____

Name **Relationship to patient**

I authorize Erhart Orthodontics to leave voicemail messages regarding patient information at the following phone numbers:

_____ _____

Phone number **Contact name/Relationship to patient**

_____ _____

Phone number **Contact name/Relationship to patient**

_____ _____

Signature of legal guardian **Date**

Dental Insurance Form

Erhart Orthodontics is not contracted with any insurance companies. However, we will submit claims to your insurance company on your behalf.

Payment in full is due from the patient and all insurance payments will be sent directly to the policyholder. We also offer interest-free payment plans on full treatment.

***Please contact your insurance company prior to your first visit to check for any waiting periods or exclusions and to verify your out-of-network orthodontic benefits*.**

Date: _____

Please provide the following information so we can submit claims to your dental insurance company:

Dental insurance company name: _____

Dental insurance company phone number: _____

Policyholder name: _____

Policyholder birthdate: _____

Policyholder ID number or social security number: _____

Policyholder employer: _____

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