grauer ORTHODONTICS

Child Information & Practice Agreement

WELCOME

To assist us in providing the most complete service, please provide the following information and health history

Tell Us About Your Child

Full Name: _____

Preferred to be called: _____

Birthdate: _____/_____/_____ _____ Male ____ Female

School: _____ Grade_____

Brothers/Sisters: _____ Age:_____

_____ Age:_____

Dentist_____

Physician_____

Referred By_____

Family Members We Have Seen_____

_____

Reason For Visit? _____

_____

Mother's Name _____

Address: _____

_____

Employed By: _____

Work Number:(_____) _____

Social Security #:_____

Cell Number:(_____) _____

Patient Lives With: _____

Father's Name:_____

Address: _____

_____

Employed By: _____

Work Number:(_____) _____

Social Security #:_____

Cell Number: (_____) _____

Email: _____

Dental Information

Please check all that apply:

- ☐ Thumb or Finger Sucking (Presently)
- ☐ Thumb or Finger Sucking (Previously)
- ☐ Speech Problems
- ☐ Swallowing Problems
- ☐ Injury to Face Or Teeth
- ☐ Nighttime Teeth Grinding
- ☐ Clicking or Pain When Opening Jaw
- ☐ Missing teeth
- ☐ Mouth Breather
- ☐ Tonsil or Adenoid problem
- ☐ Headaches

Recent Dental Checkup Date: _____/_____/_____

Previous Orthodontic Treatment Date: _____/_____/_____

What is the primary reason for your visit today?

_____

_____

_____

Please note any other factors the Doctor should know about the patient's dental health _____

_____

_____

Medical History

Do you consider your child's current overall physical health:

_____Good _____Fair _____Poor

Is your child currently under the active care of a physician or does he/she have any present health issues?

_____Yes _____No

Please Explain: _____

_____

Medical History (Cont.)

Does your child need to be premedicated with antibiotics for any heart or other conditions before dental treatment?

_____Yes _____No

Is your child taking any prescription over-the-counter-medications? (including ibuprofen, diet supplements, etc.)

_____Yes ____No

Please list each one: _____

_____

Is your child pregnant or nursing? _____Yes _____No

Is you child taking bisphosphonates? _____Yes _____No

Has your child ever had any of the following illnesses or medical problems in the past five years?

Y	N		Y	N	
__	__	Abnormal Bleeding	__	__	High Blood Pressure
__	__	Alcohol/Drug Abuse	__	__	HIV + /AIDS
__	__	Allergies	__	__	Hospitalization for
__	__	Anemia	__	__	Any Reason
__	__	Arthritis			Jaw Pain/TMJ
__	__	Artificial Bones/Joints/ Valves	__	__	Kidney Problems
__	__	Asthma	__	__	Liver Disease
__	__	Blood Transfusion	__	__	Low Back/Hip/Leg Pain
__	__	Bone / Joint Disease	__	__	Low Blood Pressure
__	__	Cancer/Chemotherapy	__	__	Lupus
__	__	Colitis	__	__	Mitral Valve Prolapse
__	__	Congenital Heart Defect	__	__	Neck/Shoulders/Arm Pain
__	__	Diabetes	__	__	Pacemaker
__	__	Difficulty Breathing	__	__	Psychiatric Care
__	__	Eating Disorders	__	__	Radiation Treatment
__	__	Emphysema	__	__	Hepatitis
__	__	Epilepsy	__	__	Rashes
__	__	Fainting Spells	__	__	Rheumatic /Scarlet Fever
__	__	Frequent Headaches	__	__	Seizures
__	__	Gingivitis or	__	__	Sexually Transmitted
__	__	Periodontal Disease	__	__	Disease
__	__	Glaucoma	__	__	Shingles
__	__	Hay fever	__	__	Sickle Cell Disease
__	__	Headaches	__	__	Spasms/Cramps
__	__	Heart Problems	__	__	Sprains/Broken Bones
__	__	Hemophilia	__	__	Thyroid Problems
__	__	Herpes/Fever Blisters	__	__	Tuberculosis (TB)
__	__	Mental Health Problems	__	__	Ulcers

If you answer yes to any of above questions, please explain:

_____

_____

Please list any significant medical condition(s) or surgeries that you have had (not listed above): _____

_____

Allergies

Are you allergic to any of the following?

Y	N		Y	N	
__	__	Aspirin	__	__	Latex
__	__	Codeine	__	__	Penicillin
__	__	Dental Anesthetics	__	__	Tetracycline
__	__	Erythromycin	__	__	Any Metals
__	__	Sulfates	__	__	Other

Please list any other drugs or items that you are allergic to:

_____

_____

Your Consent

The information I have provided on this form is accurate and complete to the best of my knowledge, information, and belief. I will notify the Practice at the soonest practical moment of any changes in the information I have provided. In consideration of being accepted as a patient of the Practice, I agree to abide by the terms and conditions of this Patient Application & Practice Agreement.

By signing below, I acknowledge that I have been given time to read and have completely read (or had read to me) the preceding information in this document and I acknowledge that the Practice has explained to me in general terms the description of certain anticipated dental procedures and treatments, alternatives (including non-treatment), and the risks and inconveniences of treatments. By proceeding with each and every step in my treatment, I acknowledge: (1) I have been given the opportunity to ask any questions and any questions have been answered or explained to my satisfaction prior to performance of any treatment or procedure, and (2) I authorize the Practice to perform any and all such recommended forms of treatment, medication and therapy that may be necessary or advised. I understand that during the course of the procedures described above, it may be necessary, appropriate, or the Practice's recommendation to perform additional procedures which are unforeseen or not known to be necessary, appropriate, or recommended at the time this consent is given. I consent to and authorize the performance of such additional procedures as they deem necessary, appropriate, or recommended under the circumstances.

Signature:_____ Date: _____

Patient's Authorized Representative
(If patient is under 18 years of age or you are consenting to the care of another)
I have the legal authority to sign this consent on behalf of:
Patient Name:_____
Your Relationship to Patient: _____
Signature: _____ Date: _____

AUTHORIZATION

I authorize the release of medical and dental information to insurance carriers and to other health care providers involved in my care and the use of records by Dr. Grauer for teaching purposes and scientific publication. In the future, please advise Dr. Grauer of any changes in your child's medical or dental health while under the care of our office. I hereby authorize Dr. Grauer to obtain credit reports if necessary.

_____ _____
Signature Date