Wendy Struss Willett, D.D.S., M.S.

Orthodontist

10015 Broadway • Suite F • Pearland, TX 77584 • 713-436-4280 • Fax 713-436-4260

WELCOME

We would like to welcome you and your child to our office: Our goal is to make every child's visit pleasant & educational

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____

LAST FIRST MI

Name Preferred: _____ ❑ Male ❑ Female

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Child's Home #: _____ SS#: _____

Child's Home Address: _____

City: _____ State _____ Zip _____

Email: _____

2 Who is Accompanying the Child Today

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Who may we Thank for reffering you? _____

Other family members seen by us: _____

_____ Relationship _____

Previous / Present Dentist: _____

Last Visit Date: _____

3 Mother's Information

❑ **Mother** ❑ **Step Mother** ❑ **Guardian**

Name: _____

Work #: _____ Ext: _____ Home #: _____

Employer: _____ How long? _____

Occupation: _____ SS #: _____

Father's Information ❑ Father ❑ Step Father ❑ Guardian

Name: _____

Work #: _____ Ext: _____ Home #: _____

Employer: _____ How long? _____

Occupation: _____ SS #: _____

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

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____

CITY STATE ZIP

Work #: _____ Ext: _____ Home #: _____

Employer: _____

SS#: _____ Date of Birth: _____

_____

Signature of Responsible Party Date

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Realtionship to Patient: _____

Insured's Birthday: ___/___/___ & SS #: _____

Insured's Employer: _____

Orthodontic Coverage? ❑ Yes ❑ No Max. Amt. _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Realtionship to Patient: _____

Insured's Birthday: ___/___/___ & SS #: _____

Insured's Employer: _____

Orthodontic Coverage? ❑ Yes ❑ No Max. Amt. _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

Work #: _____ Home #: _____

6 Why did you bring the child to the orthodontist today?

_____

_____

Has the child ever had a serious/difficult problem associated with precious dental work? ❑ yes ❑ No

Is the child's water fluoridated? ❑ yes ❑ No

Is the child taking fluoridated supplements? ❑ yes ❑ No

Has the child ever had any pain/tenderness in their jaw joint (TMJ/TMD)? ❑ yes ❑ No

Does the child brush their teeth daily? ❑ yes ❑ No

Floss their teeth daily? ❑ yes ❑ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician?

❑ yes ❑ No

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that the childis currently taking:

_____

_____

Please list all drugs that the child is allergic to: _____

_____

7 Has the child ever had any of the following medical problems?

Y	N	Heart Murmur	Y	N	Congenital Heart Defect
Y	N	Cancer	Y	N	Convulsions/Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic Fever	Y	N	Hearing Impairment
Y	N	HIV +/ AIDS	Y	N	Any Operations
Y	N	Hemophilia	Y	N	Any stays in a hospital
Y	N	Asthma	Y	N	Kidney/Liver Problems
Y	N	Hepatitis	Y	N	Handicaps/Disabilities
Y	N	Tuberculosis (TB)	Y	N	Allergies to any drugs

Please discuss any serious medical problems that the child has had: _____

_____

8 Does the child have any of the following habits?

Y	N	Thumb/Finger Sucking
Y	N	Lip Sucking/Biting
Y	N	Nail Biting
Y	N	Nursing Bottle Habits

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

9

I understand that the infomation that I have given today is correct to the best of my knowledge. I aslo understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status.

I certify that my minor/child is covered by insurance with _____

Name of insurance company(ies)

and assign directly to Dr. Wendy Struss Willett all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

Office Use Only Office Use Only **Office Use Only**

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____