201 West Washington Street · Benton, IL 62812 · 618-438-2815

300 Small Street · Harrisburg, IL 62946 · 618-252-0770

3315 Patriot Court · Herrin, IL 62948 · 618-997-1800

www.childersbraces.com

Date ____________

Patient Information

Patient's Name ______________________________ Nickname ______________
Last First Middle

Address ______________________________ Age ________ Male/Female
Street City State Zip

Home Phone ( ) ______________ Birth Date ______________ Social Security ______________

E-Mail Address ______________ If patient is a minor, give parent's or guardian's name ______________

School ______________ Grade ______ Employer ______________ # of yrs. Employed ______

How did you hear about our office? ______________ Your Hobbies/Interests ______________

Siblings/Children Yes/No Name/Age ______________ Name/Age ______________ Name/Age ______________

Responsible Party Information / Custodial Parent (The child should reside in this household)

Name ______________________________ Social Security ______________
Last First Middle

Residence ______________________________ How long at this address ______________
Street City State Zip

Mailing Address ______________________________

Previous Address (if less than 3 years) ______________________________ How long ______________

Home Phone ( ) ______________ Cell Phone ( ) ______________

Birth Date ______________ Relationship to patient ______________ Marital Status ______________

Employer ______________ Occupation ______________ No. yrs. Employed ______ Work Phone ( ) ______________

Spouse's Name ______________ Birth Date ______________ Relationship to patient ______________
Last First Middle

Spouse's Employer ______________ Spouse's Social Security ______________

Occupation ______________ No. of yrs. Employed ______________ Work Phone ( ) ______________

Orthodontic Insurance Information

Primary Insured's Name ______________ Birth Date ______________ Social Security ______________

Primary Insured's Address ______________________________ Primary Phone ( ) ______________

Employer ______________ Insured's ID ______________ Group # ______________

Insurance Company ______________ Insurance Company Dental Claims Phone ( ) ______________

Insurance Company Dental Claims Address ______________________________

Insured's Relationship to Patient ______________ Do you have dual coverage? Yes No (If Yes please complete below)

Secondary Information

Secondary Insured's Name ______________ Birth Date ______________ Social Security ______________

Secondary Insured's Address ______________________________ Primary Phone ( ) ______________

Employer ______________ Insured's ID ______________ Group # ______________

Insurance Company ______________ Insurance Company Dental Claims Phone ( ) ______________

Insurance Company Dental Claims Address ______________________________

Secondary Insured's Relationship to Patient ______________________________

Please circle if you are presently or have been treated in the past for any of the following:

- Allergies
- AIDS / HIV
- Anemia
- Arthritis
- Aspirin
- Asthma/Breathing Disorders
- Autoimmune Disorders
- Cold Sores/Fever Blisters
- Diabetes
- Heart Murmur
- Congenital Heart Defect
- Down Syndrome
- Drug Allergies
- Endocrine Problems
- Emotional Problems
- Epilepsy
- Glaucoma
- Heart Conditions
- Hepatitis
- Headaches
- Bleeding Disorders
- Radiation / Chemotherapy
- High Blood Pressure
- Immune Problems
- Kidney Problems
- Low Blood Pressure
- Mouth Breathing
- Muscular Disorders
- Nervous Disorders
- Organ Transplant
- Pneumonia
- Tonsils /Adenoids Removed
- Tobacco Use
- Pregnant
- Periodontal (gum) Problems
- Pain While Chewing
- Rheumatic Fever
- Seizures
- Speech Problems
- Tuberculosis
- TMJ
- Tooth Grinding
- Fainting or Dizziness
- Latex Allergy

Present Dentist ______________________ Present Physician ______________________

YES NO Are there any medical conditions we have not discussed that we should be aware of? ______________________

YES NO Are you taking any medications? ______________________

YES NO Are you allergic to any medications? ______________________

YES NO Have there ever been any injuries to face, mouth, or teeth? ______________________

YES NO Have you had any previous orthodontic treatment or evaluation? ______________________

YES NO Are you aware that some appointments will be during school/work hours? ______________________

YES NO Do you authorize any other person(s) to receive medical / financial information?

If yes, who ______________________

YES NO Is any part of your mouth sensitive to temperature? Where? ______________________

YES NO Is any part of your mouth sensitive to pressure? Where? ______________________

YES NO Do your gums bleed when you brush? ______________________

YES NO Is pre-medication needed for dental appointments? ______________________

What concerns you most about your teeth? ______________________

Remarks ______________________

Emergency Information

Person to contact in case of emergency ______________________ **Phone # ( )** ______________ **Relationship** __________

Address ______________________

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, and in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some changes after treatment. I also understand that my diagnostic records and my name may be used for educational and promotional purposes.

I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. I also authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr. Kyle Childers, DMD, MS. In order to bill your insurance we must have the insured's date of birth, social security number and ID number as requested in the insurance section.

I understand that where appropriate, credit bureau reports may be obtained.
I hereby state that I have read the above paragraph and that I have truthfully to the best of my ability answered all of the above questions.
Signature (Parent's Signature if a minor) ______________________ Date ______________