DR. MICHAEL W. ROWE
ORTHODONTIST

Please fill out this form completely in order for our office to prepare your clinical records.
Offices: ❒ St. Petersburg ❒ Largo ❒ Tampa ❒ Dade City

PLEASE PRINT

INFORMATION ABOUT YOUR CHILD

Today's Date _____ ❒ Male ❒ Female

Child's Name _____
LAST FIRST MI.

Child prefers to be called _____

DOB ___/___/___ Age _____

School _____ Grade _____

Hobbies/Sports _____

Child's Home # (___) _____

Child's Home Address

Who has legal custody of this child? _____

Bothers / Sisters with ages _____

Parents Marital Status _____

General Dentist _____

Last visit to dentist _____

Who referred you to us? _____

PARENT / GUARDIAN INFORMATION

❒ Birth Mother ❒ Step Mother ❒ Guardian

Name _____

SS # ___-___-___ DOB ___/___/___

Home # _____ DL # _____

Email Address _____

Employer _____

Work # (___) _____ Cell # (___) _____

❒ Birth Father ❒ Step Father ❒ Guardian

Name _____

SS # ___-___-___ DOB ___/___/___

Home # _____ DL # _____

Email Address _____

Employer _____

Work # (___) _____ Cell # (___) _____

INSURANCE INFORMATION / PRIMARY

Orthodontic Coverage ❒ Y ❒ N Dental Coverage ❒ Y ❒ N

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (___) _____

Group # (Plan #, Policy #) _____

Insured's Name _____ DOB ___/___/___

Relation to Patient _____ Insured's ID # _____

Insured's Employer _____

Employer's Address _____

INSURANCE INFORMATION / SECONDARY

Orthodontic Coverage ❒ Y ❒ N Dental Coverage ❒ Y ❒ N

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (___) _____

Group # (Plan # or Policy #) _____

Insured's Name _____ DOB ___/___/___

Relation to Patient _____ Insured's ID # _____

Insured's Employer _____

Employer's Address _____

ACCOUNT RESPONSIBILITY

Name _____ Relation _____

Billing Address _____

_____

Previous Address _____

_____

Home # _____ DL # _____

Cell # _____ SS # ___-___-___

Work # _____ Ext. _____

Person Responsible for Making Appts. _____

CONTINUED ON BACK

MEDICAL HISTORY

Is your child's current physicial health ❒ Good ❒ Fair ❒ Poor

Is your child currently under the care of a physician?

❒ Yes ❒ No Explain: _____

_____

_____

Has your child had a history or a current problem with:

Y N	Abnormal Bleeding	Y N	Convulsions / Epilepsy
Y N	ADD / ADHD	Y N	Diabetes
Y N	Allergies to any Drugs	Y N	Handicaps / Disabilities
Y N	Allergic to Latex	Y N	Hearing Impairment
Y N	Allergic to Metals	Y N	Heart Murmur
Y N	Allergic to Plastic	Y N	Hemophilia
Y N	Any Hospital Stays	Y N	Hepatitis
Y N	Any Operations	Y N	HIV+ / AIDS
Y N	Artificial Bones / Joints / Valves	Y N	Kidney / Liver Problems
Y N	Asthma	Y N	Lupus
Y N	Cancer	Y N	Rheumatic / Scarlet Fever
Y N	Congenital Heart Defect	Y N	Tuberculosis (TB)

Please list any serious medical condition(s) that your child has ever had: _____

_____

_____

Is your child currently under the care of a physician? ❒ Yes ❒ No

Child's Physician: _____

Phone # _____ Date of Last Visit _____

Has puberty begun? ❒ Yes ❒ No

Has menstruation begun? (Girls) ❒ Yes ❒ No

List any drugs your child is currently taking: _____

_____

Neighbor or Relative not living with you:

Name _____ Phone (___) _____

Address _____

_____

Our practice is HIPPA Compliant and meets or exceeds the infection control standards mandated by OSHA, CDC & ADA.

DENTAL HISTORY

Your main concerns you would like orthodontics to accomplish?

_____

Has your child ever taken Phen-Fen? ❒ Yes ❒ No

(Also known as Redux or Pondimin) If so, when? _____

Evaluated or had previous orthodontic treatment? ❒ Yes ❒ No

Previous or current pain / tenderness / discomfort in jaw joint (TMJ / TMD)? ❒ Yes ❒ No

Your child's current dental health is ❒ Good ❒ Fair ❒ Poor

Ever had injury to ❒ Face ❒ Mouth ❒ Teeth ❒ Chin

Have the adenoids or tonsils been removed? ❒ Yes ❒ No

Informed of missing / extra permanent teeth? ❒ Yes ❒ No

Does your child have any speech problems? ❒ Yes ❒ No

Dpes our child brush his / her teeth daily? ❒ Yes ❒ No

Floss his / her teeth daily? ❒ Yes ❒ No

Has your child experienced any of the following?

Y N	Clenching / Grinding Teeth	Y N	Nursing Bottle Habits
Y N	Lip Sucking / Biting	Y N	Speech Problems
Y N	Mouth Breather	Y N	Thumb / Finger Sucking
Y N	Nail Biting	Y N	Tongue Thrust

List any musical instruments played: _____

The information I have provided here is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and that it is my responsibility to provide this office with any changes in my child's medical status.

I understand that ***I am responsible*** for any payment of services rendered, including any co-payments and deductibles, that my ***insurance does not cover***. I hereby authorize payment of these insurance benefits (otherwise payable to me) directly to this office. Also, if my insurance is terminated during active treatment, I am responsible for the balance.

_____

Parent's Signature (or Legal Guardian) *Date*

FOR OFFICE USE ONLY

Medical and Dental information has been verbally reviewed with this patient. Initials _____ Date _____

Doctor's Comments: _____

_____

_____

_____