



Piper Orthodontics

901-756-4316 PiperOrtho.com

Fred Piper DDS, MS, PC

Specialist in Orthodontics

1. TELL US ABOUT YOUR CHILD

Today's Date: ____/____/____ Male Female

Child's Name: _____

Nickname _____
Last First MI

Child's Birthdate: ____/____/____ Child's Age: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: (____) _____

Child's Home Address: _____

City State Zip Apt / Condo #

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

Other family members seen by us: _____

General Dentist: _____

Address: _____

City State Zip

Last Visit Date: _____

2. How did you hear about our practice?

Referred by Dentist

(If yes, who?) _____

Existing Patient

(If yes, who?) _____

Internet Search

Other _____

3. Mother's Information:

Responsible for Account Yes No

Name: _____

Home Address: _____

City State Zip

Hm #:(____) _____ Cell #:(____) _____

Employer: _____

Wk #:(____) _____ Ext. _____ Hm #: (____) _____

Single Widowed Married Divorced Separated

Family Email: _____

4. Father's Information:

Responsible for Account Yes No

Name: _____

Home Address: _____

City State Zip

Hm #:(____) _____ Cell #:(____) _____

Employer: _____

Wk #:(____) _____ Ext. _____ Hm #: (____) _____

Single Widowed Married Divorced Separated

Family Email: _____

5. Primary Insurance

Dental Coverage? Yes No Ortho Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Policy Owner's Name: _____

Address: _____ Phone #: _____

Relationship to Patient: _____

Policy Owner's Birthday: ____/____/____ SS#: _____

Policy Owner's Employer: _____

Secondary Insurance

Dental Coverage? Yes No Ortho Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Policy Owner's Name: _____

Address: _____ Phone #: _____

Relationship to Patient: _____

Policy Owner's Birthday: ____/____/____ SS#: _____

Policy Owner's Employer: _____

6. Dental History

What are the main concerns that you would like orthodontics to address? _____

Has your child ever been evaluated or had orthodontic treatment before? Yes No

Have there been any injuries to the face, mouth, teeth or chin? _____ Yes No

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ / TMD)? Yes No

Does your child brush his / her teeth daily? Yes No

Floss his / her teeth daily? Yes No

Child's Physician: _____

Phone # (_____) _____ Date of Last Visit: _____

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

Has puberty begun? Yes No

Has menstruation begun? (Girls) Yes No

Please describe your child's current physical health:

Good Fair Poor

Please list all drugs that your child is currently taking: _____

Please list all drugs/things that your child is allergic to: _____

7. Medical History

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

- | | |
|--|----------------------------------|
| Y N Abnormal Bleeding | Y N Diabetes |
| Y N ADD / ADHD | Y N Handicaps / Disabilities |
| Y N Allergies to any Drugs | Y N Hearing Impairment |
| Y N Allergic to Latex / Metals | Y N Heat 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 Problems |
| Y N Asthma | Y N Liver Problems |
| Y N Cancer | Y N Rheumatic / Scarlet Fever |
| Y N Congenital Heart Defect | Y N Sickle Cell Disease / Traits |
| Y N Convulsions / Epilepsy | Y N Tuberculosis (TB) |

Please discuss any medical problems that your child has had:

8. Oral Habits

Does / did your child have any of the following habits?

- | | |
|--------------------------------|----------------------------|
| 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 |

9. I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the staff to perform the necessary orthodontic services my child may need.

Signature of parent or guardian

Date

The Parent or Guardian who accompanies the child is responsible for payment at the time services are rendered.

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I verbally reviewed the medical / dental information above with the parent / guardian and patient name herein.

Initials: _____ Date: _____

Doctor's Comments: Class _____
