

# BEKISH Orthodontics

Dr. Daniel J. Bekish, DMD, MS

## New Patient Information CHILD

Today's Date: \_\_\_\_\_  
Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_  
last first middle

Home Address \_\_\_\_\_

Phone \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex:  Female  Male

List Sports & Interest of Patient \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Last visit date \_\_\_\_\_ Referred by \_\_\_\_\_

Patient Lives with:  both parents  mother  father  guardian

Parent's Marital Status:  married  separated  divorced  remarried  
 widowed  single

Father's Name \_\_\_\_\_ Employment \_\_\_\_\_

Email address: \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Employment \_\_\_\_\_

Email address: \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Name & Ages of Children in family \_\_\_\_\_

Main concern(s) for today's appointment: \_\_\_\_\_

Does the patient want orthodontic treatment? \_\_\_\_\_

## Medical History

Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	Hay Fever	<input type="radio"/> Yes	<input type="radio"/> No	HIV	<input type="radio"/> Yes	<input type="radio"/> No
Heart Trouble	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Tonsillitis	<input type="radio"/>	<input type="radio"/>
Rheumatic fever	<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>
Bone disorders	<input type="radio"/>	<input type="radio"/>	Convulsions	<input type="radio"/>	<input type="radio"/>	Endocrine-thyroid	<input type="radio"/>	<input type="radio"/>
Abnormal bleeding	<input type="radio"/>	<input type="radio"/>	ADD/ADHD	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>

Any other medical concerns? \_\_\_\_\_

List any drugs or medications now being taken \_\_\_\_\_

Why? \_\_\_\_\_

Why? \_\_\_\_\_

Is the patient allergic to any medications? \_\_\_\_\_

Is the patient allergic to? **LATEX** **METALS/NICKEL** **PLASTICS**

Have tonsils and adenoids been removed? \_\_\_\_\_ Does patient snore? \_\_\_\_\_

Has the patient reached puberty? \_\_\_\_\_ Patient most resembles: Mother  Father  Both

Height: Patient \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_

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# Dental History

Have there been any injuries to the face, mouth or teeth? \_\_\_\_\_  
Did the patient ever suck thumb or fingers? \_\_\_\_\_ Until what age? \_\_\_\_\_  
Does the patient have any problems with speech? \_\_\_\_\_  
Does the patient play a wind musical instrument? \_\_\_\_\_ What kind? \_\_\_\_\_  
Have you been informed of any missing or extra permanent teeth? \_\_\_\_\_  
Has the patient had any previous orthodontic examinations? \_\_\_\_\_  
Where any x-rays taken? \_\_\_\_\_  
Is the patient especially apprehensive towards dental visits? \_\_\_\_\_  
Does the patient have any congenital abnormalities? \_\_\_\_\_  
Does the patient have any of the following habits? MOUTH BREATHER \_\_\_\_\_ NAIL BITING \_\_\_\_\_  
NURSING BOTTLE HABITS \_\_\_\_\_ LIP SUCKING/ BITING \_\_\_\_\_ TONGUE THRUST \_\_\_\_\_

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# TMJ History

Has the patient had any discomfort or clicking in the jaw-joints near the ears? \_\_\_\_\_  
Does the patient clench or grind his/her teeth? \_\_\_\_\_  
Does the patient have frequent head or neck aches? \_\_\_\_\_  
Does the patient have pain or ringing in the ears? \_\_\_\_\_  
Has the patient's jaw ever locked or slipped out of place? \_\_\_\_\_  
Are his/her teeth sore or sensitive? \_\_\_\_\_

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# Insurance Information

Person Responsible for Account \_\_\_\_\_  
last first middle

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address (if different than patient) \_\_\_\_\_  
Home Phone \_\_\_\_\_ SS # \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_

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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 dental staff to perform the necessary dental services my child may need.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

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Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_