RYANBOYER ORTHODONTIST

# Welcome To Our Office!

Ryan A. Boyer DDS MSD
Specialist in Orthodontics

Date _____

## PATIENT INFORMATION

Name: _____ _____ Home Phone #: _____
First Middle Last Nickname

Address: _____ Email: _____ Birthday: _____

City: _____ State: _____ Zip: _____ Age: _____ Sex: ☐ M ☐ F

Referred By: _____ School: _____ Grade: _____

## WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Who does child reside with? ___ Mom ___ Dad ___ Both ___ Other _____
Parent's Marital Status: __ Single ___ Widowed ___ Married ___ Divorced ___ Separated

## PARENTS INFORMATION

**FATHER** ☐ Step ☐ Guardian

Name: _____
Father's Address Same As Child's: ☐ yes ☐ no
Other Address: _____
Home #: _____ Work #: _____
Employer: _____ Cell: _____
Email: _____

**MOTHER** ☐ Step ☐ Guardian

Name: _____
Mother's Address Same As Child's: ☐ yes ☐ no
Other Address: _____
Home #: _____ Work #: _____
Employer: _____ Cell: _____
Email: _____

## MEDICAL INFORMATION

Child's Physician: _____ Phone #: _____ Date of Last Visit: _____

| | YES | NO |
|---|---|---|
| Is Patient Under the Care of a Physician: | | |
| Is the Patient in Good Health: | | |
| ADD/ADHD: | | |
| Any Hospital Stays/Operations: | | |
| Any Heart Disease/Defects: | | |
| H.I.V. Positive/AIDS: | | |
| Artificial Bones, Joints/Valves: | | |
| Cancer: | | |
| Any High or Low Blood Pressure: | | |
| A History of Fainting or Dizziness: | | |
| Heart Murmur: | | |
| Hemophilia: | | |
| Hepatitis/Liver Problems: | | |
| Sickle Cell Disease/Traits: | | |

| | YES | NO |
|---|---|---|
| Handicaps/Disabilities/Hearing Impairment: | | |
| Diabetes: | | |
| Asthma or Hay Fever: | | |
| Tuberculosis: | | |
| Abnormal Bleeding: | | |
| Any Seizure Disorder: | | |
| Lupus: | | |
| Kidney Problems: | | |
| Rheumatic Fever/Scarlet Fever: | | |
| Allergic to Latex / Metals: | | |
| Has puberty begun: | | |
| Has menstruation begun? (Girls): | | |
| Patient ever taken Phen-Fen?(aka Redux or Pondium): | | |
| If yes, when? | | |

Please discuss any medical problems that your child has had: _____
List Any Medications Currently Taking: _____
**Is the Patient Allergic to Anything, if so what:** _____
Any other disease, condition, or problem not listed above that we should know about: _____

## DENTAL HISTORY

Child's Dentist: _____ Phone #: _____ Date of Last Visit: _____

| | YES | NO |
|---|---|---|
| Has the Patient Been Evaluated or had Orthodontic Treatment Before: | | |
| Has the Patient Seen a General Dentist in the Last Year: | | |
| Has the Mouth, Face or Teeth Been Injured by a Fall or Accident: | | |
| Frequent Headaches: | | |
| Are You Aware of Any "Gum" Problems: | | |
| Have the Patient's Tonsils or Adenoids Been Removed: | | |
| Know of Any Missing or Extra Permanent Teeth: | | |
| Pain/Clicking/Popping in Jaw Joint (TMD/ TMJ): | | |

| | YES | NO |
|---|---|---|
| Thumb/Finger Sucking: | | |
| Mouth Breather: | | |
| Finger Nail Biting: | | |
| Tongue Thrusting: | | |
| Clench/Grind Teeth: | | |
| Speech Problems: | | |
| Nursing/Bottle: | | |
| Brush Twice a Day: | | |

Floss: ☐ Every Day ☐ Some Days ☐ Never

In Your Own Words What is the Orthodontic Problem: _____

## PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

_____

City State Zip

Home Address if different: _____

_____

Home/ Cell #: _____ DL #: _____

Employer: _____ Wk #:_____

SS#: _____ Birthdate: _____

## PRIMARY INSURANCE

Dental Coverage? ___ Yes ___ No Ortho Coverage? ___ Yes ___ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group/ Policy #: _____

Policy Owner's Name: _____ Relation to Patient: _____

Policy Owner's Birth Date: ___/___/___ ID or 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/ Policy #: _____

Policy Owner's Name: _____ Relation to Patient: _____

Policy Owner's Birth Date: ___/___/___ ID or SS#: _____

Policy Owner's Employer: _____

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

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This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____

Signature of parent or guardian Date

**The Parent or Guardian who accompanies the child is responsible for payment.**
**This office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA**

******* Please note that some longer procedures are only done in the mornings during school hours *******

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