Designing smiles that last a lifetime.

Dr. Ashley L. Reynolds
CRESCENT ORTHODONTICS PLLC

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

1 Tell Us About Your Child

Date ______ Nickname ______

Patient's Name ______ (LAST / FIRST / MI)

Address ______ APT/CONDO #

______ CITY / STATE / ZIP

Birthdate ______ Age ______ ☐ Male Female

Email ______ SSN ______

School ______ Grade

Sports / Hobbies ______

Whom may we thank for referring you? ______

Other family members seen by us ______

General Dentist ______ Date of Last Visit ______

2 Parent / Legal Guardian Information

☐ Mother's Information ☐ STEP MOTHER ☐ GUARDIAN

.Name ______

Address ______ APT/CONDO #

______ CITY / STATE / ZIP

Phone ______ Date of Birth ______

SSN ______ Driver's License ______

Email ______

Employer ______ Work Phone ______

☐ Father's Information ☐ STEP FATHER ☐ GUARDIAN

Name ______

Address ______ APT/CONDO #

______ CITY / STATE / ZIP

Phone ______ Date of Birth ______

SSN ______ Driver's License ______

Email ______

Employer ______ Work Phone ______

3 Person Responsible for Account

Name ______

Address ______ APT/CONDO #

______ CITY / STATE / ZIP

Phone ______ Date of Birth ______

SSN ______ Driver's License ______

Employer ______ Work Phone ______

4 Orthodontic Insurance Information

PRIMARY

Orthodontic Coverage ☐ Yes ☐ No

Insured's Name ______ Relation ______

Insured's Birthdate ______ Insured's SSN ______

Insured's Employer ______

Insurance Co. Name ______

Insurance Co. Address ______

Insurance Co. Phone ______

Group No. (Plan, Local or Policy #) ______

SECONDARY

Orthodontic Coverage ☐ Yes ☐ No

Insured's Name ______ Relation ______

Insured's Birthdate ______ Insured's SSN ______

Insured's Employer ______

Insurance Co. Name ______

Insurance Co. Address ______

Insurance Co. Phone # ______

Group No. (Plan, Local or Policy #) ______

5 Emergency Contact Information

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name/Relation ______

Phone ______

Email ______

Ashley L. Reynolds D.D.S., M.S.
TEL 248.437.3377
www.crescentorthodontics.com

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6 Medical History

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

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

Please discuss any medical problems that your child has had

____

____

____

7 Dental History

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

____

____

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

(Also known as Redux or Pondimin) If yes, when? ____________

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

List any musical instruments played: ____________

Have adenoids or tonsils been removed? ☐ Yes ☐ No

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

Do you now or have you ever experienced pain / discomfort in your 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? (FEMALE PATIENTS ONLY) ☐ Yes ☐ No

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

☐Y ☐N Latex ☐Y ☐N Metals/Nickel ☐Y ☐N Plastics

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

8 Release /Agreement

I authorize this office to affix my name to any and all claims or documents related to any and all dental benefits due me and my dependents through my employment. I authorize payment of dental benefits otherwise payable to me, directly to this office.

I understand that where appropriate, credit bureau reports may be obtained.

I certify that I have read and understand the foregoing questions. To the best of my knowledge, the foregoing questions have been completely and accurately answered. In addition, I will notify the doctor of any change in my health history.

Patient Signature: ____________

Parent/Legal Guardian Signature: ____________

9 Updated Health History Personal Information

Date ______	Date ______	Date ______	Date ______	Date ______
Initials ______	Initials ______	Initials ______	Initials ______	Initials ______