180 ORTHODONTICS
SHABBIR T. ADENWALLA, DMD, MS
19053 Bagley Rd. Suite 1
Middleburg Heights, Ohio 44130
(440) 243-9575

Thank you for trusting us with your orthodontic care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.
Patient: Last Name _____
Patient: First name _____
Date: _____ Age _____

PATIENT

Preferred Name _____ Birthdate _____Sex _____
Home Address: Street _____
City _____ State_____ Zip _____Home Phone _____
Mobile Phone _____ Email address _____ SS # _____
School _____ Grade _____
Hobbies/Sports _____ _____
Who may we thank for referring you? _____
Other siblings/ages _____ _____
General Dentist _____ Phone _____ Last Visit _____
Who is accompanying child today? _____ Do you have legal custody? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Name _____Relation _____
Work #_____Mobile # _____Home # _____

RESPONSIBLE PARTY INFORMATION

Who is responsible for account? _____ Parent's Marital Status _____
Last _____First _____MI _____
Billing Address: _____
Relation _____SS#_____ DL #_____

PRIMARY DENTAL INSURANCE – ORTHODONTIC BENEFITS: YES/NO

Insured's Full Name _____ Birthdate _____
Relationship to Patient _____ SS # _____ DL # _____
Insurance Co_____ Employer _____ Occupation _____
Insurance Address _____ Ins Phone _____
Contract ID _____ Group #_____

SECONDARY DENTAL INSURANCE – ORTHODONTICBENEFITS: YES/NO

Insured's Full Name _____ Birthdate _____
Relationship to Patient _____ SS # _____ DL # _____
Insurance Co_____ Employer _____ Occupation _____
Insurance Address _____ Ins Phone _____
Contract ID _____ Group #_____

DENTAL HISTORY

Main concerns that you would like orthodontics to accomplish? _____

Has your child ever been evaluated for orthodontic treatment? _____

Does your child require antibiotics before dental treatment? _____

Has the child ever experienced pain/discomfort in his/her jaw joint (TMJ/TMD)? _____

Has your child ever had an injury to face, mouth or teeth? _____

Does your child have any missing or extra permanent teeth? _____

Have adenoids or tonsils been removed? _____

Does your child brush and floss his/her teeth daily? _____

Does/did the child experience any of the following?

☐ Breast fed ☐ Lip sucking/Biting ☐ Nail biting ☐ Speech problems ☐ Tongue thrust
☐ Clenching/Grinding teeth ☐ Mouth breather ☐ Nursing bottle habits ☐ Thumb/finger sucking ☐ Used pacifier

List any musical instruments played _____

MEDICAL HISTORY

Child's Physician _____ Phone # _____ Date of last visit _____

Has puberty begun? ☐ Yes ☐ No Has menstruation begun? ☐ Yes ☐ No

Child's current physical health ☐ Good ☐ Fair ☐ Poor Are the child's immunizations current? ☐ Yes ☐ No

Has the child experienced any of the following medical problems?

☐Abnormal bleeding	☐Cancer	☐ Hearing impairment	☐ Mitral valve prolapse
☐ ADD/ADHD	☐ Congenital heart defect	☐ Heart murmur	☐ Prosthetics
☐ AIDS/HIV+	☐ Convulsions	☐ Hemophilia	☐ Rheumatic fever
☐ Hospital stays/Operations	☐ Diabetes	☐ Hepatitis	☐ Scarlet fever
☐ Artificial bones/Joints/Valves	☐ Epilepsy	☐ Kidney problems	☐ Sickle cell disease/Traits
☐ Asthma	☐ Handicaps/Disabilities	☐ Liver problems	☐ Tuberculosis (TB)

Has the child ever taken any diet pills such as Phen-Fen, also known as Redux or Pondimin? _____

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please list any serious medical problems the child has ever had _____

Please list all drugs that the child is currently taking _____

Is your child allergic to: Latex: ☐ Yes ☐ No Nickel/Metals: ☐ Yes ☐ No Plastics: ☐ Yes ☐ No

List all other drugs/things your child is allergic to _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest 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 any necessary dental/orthodontic services that my child may need during diagnosis and treatment with my informed consent.

_____ _____
Signature Date

I understand that I am responsible for payment of services rendered to my child and also responsible for paying any co-payment and deductibles that my child's insurance does not cover. I hereby authorize payment of the group insurance benefits for my child (otherwise payable to me), directly to this office.

_____ _____
Signature Date