



NORTH EAST
ORTHODONTICS

Jay M. Decoteau D.M.D., P.C.

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

CHILD'S NAME: _____ Nick Name: _____ Date: _____
Last First Middle
 Birthdate: _____ Age: _____ Male Female Home Phone #: _____
 Address: _____
Street City State Zip
 Sports/Hobbies: _____ Child's Email: _____
 School: _____ Grade: _____ List brothers / sisters with age: _____

Who is accompanying your child today? _____ Relation _____ Do you have legal custody of this child? Yes No
 Whom may we thank for referring you to our office? _____

PARENT INFORMATION

PARENT/GUARDIAN #1: Mother Step Mother Guardian Other _____ Social Security #: _____ - _____ - _____
 Name: _____ Birthdate: _____ Email: _____
Last First Middle
 Mailing Address: _____
Street City State Zip
 Home Phone #: _____ Cell Phone #: _____ Cell Phone Provider: _____
 Employer Name and Address: _____ Occupation: _____

PARENT/GUARDIAN #2: Father Step Father Guardian Other _____ Social Security #: _____ - _____ - _____
 Name: _____ Birthdate: _____ Email: _____
Last First Middle
 Mailing Address: _____
Street City State Zip
 Home Phone #: _____ Cell Phone #: _____ Cell Phone Provider: _____
 Employer Name and Address: _____ Occupation: _____

Parents Marital Status: Married Single Divorced Separated Widowed Partnered

Person responsible for account: _____ Relation to patient: _____
 Mailing Address: _____
 Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____ Email: _____

DENTAL INSURANCE INFORMATION

Do you have orthodontic coverage? Yes No (If no, skip to next section)

PRIMARY ORTHODONTIC INSURANCE Insured's Name : _____ Birthdate: _____
 Insurance Company Name: _____ Group #: _____ ID #: _____
 Insurance Co. Address: _____ Phone #: _____
Do you have dual coverage? Yes _____ No _____

SECONDARY ORTHODONTIC INSURANCE Insured's Name: _____ Birthdate: _____
 Insurance Company Name: _____ Group #: _____ ID #: _____
 Insurance Co. Address: _____ Phone #: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone #: _____ Relation to Patient: _____

MEDICAL HISTORY

PHYSICIAN: _____	Date of Last Visit: _____			
Address: _____	Phone #: _____			
ALLERGIES:				
Yes No	Is your child allergic to any latex, metals, nickel or plastics? <i>Please list:</i> _____			
Yes No	Is your child allergic to any medication / things? <i>Please list:</i> _____			
Has your child ever had any of the medical conditions listed below: Yes _____ No _____ <i>If yes, please circle:</i>				
Abnormal Bleeding	Bone Disorders	Gastrointestinal Disorders	High/Low Blood Pressure	Psychiatric Problems
ADD or ADHD	Cancer/Tumor	Hearing Impairment	HIV/AIDS	Radiation/Chemotherapy
Anemia	Congenital Heart Defect	Heart Problems/Murmur	Kidney Problems	Rheumatic Fever
Artificial Bones/Joints/Valves	Diabetes	Hemophilia	Nervous Disorders	Severe/Frequent Headache
Asthma	Dizziness	Hepatitis/Liver Problems	Pneumonia	Sinus Problems
Autism	Epilepsy/Seizures	Herpes/Fever Blisters	Prolonged Bleeding	Tuberculosis
Is your child taking any medication? <i>Please list:</i> _____				
Is there a history of a major illness? <i>Please list:</i> _____				
Has your child had any operations or been involved in a serious accident? <i>Please list:</i> _____				
Are there any handicaps/disabilities that we should be aware of? _____				
Are there any medical conditions we have not discussed that you feel we should be aware of? _____				

DENTAL HISTORY

GENERAL DENTIST: _____	Date of Last Visit: _____			
What concerns you most about your child's teeth? _____				
Has your child ever had any of the habits listed below: Yes _____ No _____ <i>If yes, please circle:</i>				
Clenching Teeth	Thumb / Finger Habit	Lip Sucking	Mouth Breathing	Nail Biting
Grinding Teeth	Tongue Thrust	Lip Biting	Speech Problems	Bottle Habit
Yes No	Has your child ever been evaluated for orthodontic treatment? _____			
Yes No	Is your child sensitive or self-conscious about his/her teeth? _____			
Yes No	Has anyone in the family received orthodontic treatment? _____			
	If yes, how did they feel about the result? _____			
Yes No	Has your child ever experienced any unfavorable reaction to dentistry? _____			
Yes No	Is your child presently in any dental pain? _____			
Yes No	Is any part of your child's mouth sensitive to temperature or pressure? Where? _____			
Yes No	Have there been any injuries to face, mouth, or teeth? _____			
Yes No	Has your child been informed of any missing or extra teeth? _____			
Yes No	Has your child ever lost or chipped any permanent teeth? _____			
Yes No	Do teeth or jaws ever feel uncomfortable first thing in the morning? _____			
Yes No	Does your child ever experience jaw clicking or popping? _____			
Yes No	Does your child experience "tension" headaches? _____			
Yes No	Does your child brush daily? _____			
Yes No	Do gums bleed when brushing? _____			

I have truthfully answered all the above questions and agree to inform this office of any changes in my child's medical or dental history. I understand that diagnostic records may be used for educational and promotional purposes. In addition, I authorize Dr. Jay Decoteau and staff to perform the necessary dental services my child needs.

Parent/Guardian Signature: _____ Date: _____

I understand that I am responsible for payment of services rendered and also for paying any co-payments and deductibles that my insurance does not cover. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Parent/Guardian Signature: _____ Date: _____

This office reserves the right to verify the credit status of patients and/or their parents prior to extending credit for orthodontic fees and may, at the discretion of the office, use the services of credit reporting services.

Parent/Guardian Signature: _____ Date: _____