

Windermere | Orlando **J** 407-258-3262 | 407-995-6029 myfamilyortho.com

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. Patient Information:							
First Name:		Middle Initials: Last Name:		ame:			
Date of Birth:		Gender:	C Male				
Street Address:	Apt./Unit #:		City:		State:	Zip Code:	
Mobile Phone:		Home Phor	ne:		Work Phone:		
Email:		Preferred contact method: C Mobile Phone C Home Phone C Work Phone		none C Email C Non	ne		
Primary Responsible Party Info	rmation:						
First Name:	Middle Initia	als:		Last Name:			
Date of Birth:	Gender:	n Male		Marital Status:	i		
Street Address:	Apt./Unit #:		City:		State:	Zip Code:	
Mobile Phone: Hor		Home Phor	Home Phone:		Work Phone:	Work Phone:	
Email:		Preferred c		:hod: lome Phone C Work Ph	none C Email C Text	t	
. Secondary Responsible Party I	nformation (optional):					
First Name:		Middle Initials:		Last Name:			
Date of Birth:	Gender:	C Male C C	ther	Marital Status:	1		
Street Address:	Apt./Unit #:		City:		State:	Zip Code:	
Mobile Phone:		Home Phor	ne:		Work Phone:		
Email:			Preferred contact method: C Mobile Phone C Home Phone C Work Phone		none C Email C Text	•	

5. What is your primary concern(s)? 6. Has your child had previous orthodontic treatment? C Yes	Friend or family (enter name)	r family (enter name) Other Website		Other	
C Yes C No 7. General Dentist Information: Dentist Name: Dential visit in last 6 months?: Any scheduled treatments? C Yes C No 8. Do you have Orthodontic Insurance? C Yes C No 9. Primary Insurance Company Member ID / Policy # Group Number Patient Relationship to Insured Insured Name Insured Phone # Insured Date of Bit C Other Insurance Card: Please take a photo of the back and front of your Insurance card. Should treatment be recoproviding your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your 1. Secondary Insurance Company Member ID / Policy # Group Number Patient Relationship to Insured Secondary Insurance Company Member ID / Policy # Group Number Patient Relationship to Insured Insured Name Insured Phone # Insured Date of Bit C Self C Spouse C Child C Other Insured Street Address Insured City Insured State Zip Code 2. Secondary Insurance Card: Please take a photo of the back and front of your Insurance card. Should treatment be reproviding your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your Insured Street Address Insured City Insured State Zip Code 2. Secondary Insurance Card: Please take a photo of the back and front of your Insurance card. Should treatment be reproviding your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your Scheck if your child has or has had any of the following: Anemia Asthma/COPD Bleeding abnormally C Anemia Bleeding abnormally C Anemia Asthma/COPD Place Bleeding abnormally C Anemia Placemaker High Blood pressure C High Blood pressure C High Blood pressure C High Blood pressure	5. What is your primary concern	(s)?			
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☐ HIV AIDS ☐ Osteoporosis ☐ Pacemaker	_				
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Other/Details:		_ Stroke	i Tobac		

Loose teach or broken fillings	14. Indicate any history of (check all the Thumb/finger sucking	nat apply); If checked "Yes", please explain. ☐ Tongue and/or swallowing problems	☐ Speech problems
Crowns/Bridges			
Snoring	•		
History of Periodontal treatment	_		_
Jaw Pain	_	, , ,	
Sensitivity when biting			
Other/Details: 15. Has patient reached puberty? C Yes C No 16. Please list any allergies: Allergy 17. List current medications and the correlating diagnosis: Medication Diagnosis 18. Any serious illnesses or operations? If yes, please describe. 19. What treatment option(s) interest you? Clear Aligners C Clear/Metai Braces Retainers 20. If treatment is recommended, how soon would you like to get started? ASAP Within the week Within the month Other: 21. What payment option(s) would you like to review? No-interest Monthly Payment Payment Payment in Full w/Special Courtesy HSAVESA 22. Is there anything else you would like us to know before your visit?: To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any chang to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.	-		
16. Please list any allergies: Allergy 17. List current medications and the correlating diagnosis: Medication Diagnosis 18. Any serious illnesses or operations? If yes, please describe. 19. What treatment option(s) interest you? Clear Aligners Clear Aligners Retainers 20. If treatment is recommended, how soon would you like to get started? ASAP Within the week Within the month Other: 21. What payment option(s) would you like to review? No-interest Monthly Payment Payment in Full w/Special Courtesy HSA/FSA 22. Is there anything else you would like us to know before your visit?: To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any chang to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.	Other/Details:		
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Signature			
	Cignoti	ure	Date

New Patient Health History - Child