RYCKMAN ORTHODONTICS

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date:_____

Child's Name:_____
Last First M.I.

Preferred Nickname?:_____ ❑ M ❑ F

Birthdate: _____ Age _____

Child's Home Address:_____

_____
City State Zip

Child's Home Phone: _____

Child's Email:_____

School:_____ Grade:_____

Hobbies/Sports:_____

2 Who Is Accompanying The Child Today?

Name:_____ Relation:_____

Do you have legal custody of this child? ❑ Y ❑ N

Who may we thank for referring you? _____

Family members treated here: _____

_____

General Dentist:_____

Last Exam Date:_____Any cavities?_____

Parent's Marital Status: ❑ Single ❑ Married
❑ Widowed ❑ Divorced ❑ Separated

3 Parent's Information

Mother ❑ Step Mother ❑ Guardian

Name:_____ DOB:_____

Email:_____

Home#:_____

Cell#:_____

Employer:_____

Work#:_____ Ext._____

Father ❑ Step Father ❑ Guardian

Name:_____ DOB:_____

Email:_____

Home#:_____

Cell#:_____

Employer:_____

Work#:_____ Ext._____

4 Person Responsible For Account

Name:_____

Relationship:_____

Billing Address:_____

_____
City State Zip

Email:_____

Home#:_____

Cell#:_____

Employer:_____

Work#:_____ Ext._____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ❑Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:_____

Group#:_____

Insured's Name:_____

Relationship to Patient:_____

Insured's Birthdate:_____/_____/_____

Insured's SS# or Subscriber ID#_____

Insured's Employer:_____

Employer's Address:_____

Employer's Phone#:_____

Please let us know if you have a second eligible dental plan so that we can give you another form to fill out.

6 Does/Did the Child Have Any of the Following?

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

Please Fill Out Page Two of This Form

1007 Shroyer Road, Dayton, OH 45419 - Phone (937) 294-1001 - Fax (937) 294-0798
3140 Dayton Xenia Road, Beavercreek, OH 45385 - Phone (937) 429-5100 - Fax (937) 294-0798
www.Braces4Dayton.com

7 What would you like orthodontics to accomplish?

What are your primary goals in seeking orthodontic treatment?

_____

_____

_____

Has the child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

List any musical instruments played _____

Have adenoids or tonsils been removed? Y N

Has your child been informed of any missing or extra permanent teeth? Y N

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ/TMD)? Y N

Does the child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Child's Physician: _____

Phone#:_____

Date of Last Visit:_____

Is child currently under the care of a physician? Y N

Has puberty begun? Y N

Has menstruation begun? (Girls) Y N

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

_____

_____

_____

Please list all drugs/things that the child is allergic to:

_____

_____

8 Has your child ever had any of the following medical problems:

Y N Abnormal Bleeding
Y N Allergies to Any Drugs
Y N Allergic to Latex/Metals
Y N Allergic to Plastics
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Bones/Joints
Y N Artificial 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 Rheumatic/Scarlet Fever
Y N Tuberculosis (TB)

9

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

The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been made. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the parent / guardian & patient named herein.

Doctor's Comments Initials: _____ Date: _____

_____

_____