Trawick Orthodontics
1100-Airport Blvd.
Pensacola, FL 32504

Dr. StephenC.Trawick, DDS

Welcome
to our Office

Tell Us About Your Child

Today's Date: ______________ Nickname:________________

Child's Name: ____
Last First Middle

Email address: ____

SS #: ______________________ Birthdate: ___/___/___

Age: ___________ Male ____ Female ____

School ________________________________ Grade ________
Hobbies ____________________Sports ___________________

Child's Hm # : (___)__________________
Child's Home Address: ________________________________
____

Who is accompanying your child today:

Name:________________________Relation:________________

Do you have legal custody of this child? ___Y ___N

Whom May We Thank For Referring You?
____

List Brothers/Sisters with age: ___________________________
____

General Dentist: _____________________________________
Last Visit Date: _______________________

Parent's Marital Status: ___Single ___Partnered ___Divorced
___Married ___Separated ___Widowed

Person Responsible for Account

Name:_____________________________Relation:___________

Billing Address:____
____

Hm # : (___)_____________ Wk # : (___)_________________
Cell #: (___)_____________ SS # :_______________________

Employer: ____

Parents Information

Mother's Information:
___Mother ___Step Mother ___ Guardian

Name:_____________________________Birthdate: ____________
Wk #: ___________________ Hm # : ______________________
Cell # : __________________ SS # : _________________________

Employer: ____
Years at Current Job: ____ Job Title: _______________________

Father's Information:
___Father ___ Step Father ___Guardian

Name: ____________________________Birthdate: _____________
Wk # : ____________________ Hm # : ____________________
Cell #: ____________________ SS # : ________________________

Employer: ____
Years at Current Job:____ Job Title: _________________________

Orthodontic Insurance

Primary Orthodontic Coverage? ___Y ___N
Insurance Co. Name: _____________________________________
Insurance Co. Address:____________________________________
Ins. Comp. Ph.# :___________________

Policy Owner Name: ___________________________________
Relationship to Patient: ______________________
Group/ Policy # : ________________________________

Policy Owner Birthdate: _____________SS # : ________________
Policy Owner Employer: _________________________________
Employer Address: ____

Secondary Orthodontic Coverage? ___Y ___N
Insurance Co. Name: _____________________________________
Insurance Co. Address: ___________________________________
Ins. Comp. Ph. # : ___________________

Policy Owner Name: ___________________________________
Relationship to Patient: ______________________
Group/Policy # : _________________________________

Policy Owner Birthdate:______________SS #: ________________
Policy Owner Employer: _________________________________
Employer Address: ____

Dental History

What main orthodontic concerns would you like to discuss?
____
____

Has your child ever taken Phen-Fen? ___Y___N

Has your child ever been evaluated by an orthodontist before? ___Y___N

Have there been any injuries to the face, mouth, or chin: ___Y___N

List any musical instrument played: ______________

Have tonsils or adenoids been removed? ______________

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

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ___Y___N

Does your child brush his teeth daily? ___Y___N

Child's's Physician: ______________

Phone # :______________ Date of last visit: ______________

Is your child under the care of a physician? ___Y___N

Has puberty begun? ___Y___N

(Girls) Has menstruation begun? ___Y___N

Please 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

Medical History

Has your child ever had any of the following:

Y N Abnormal Bleeding
Y N ADD/ADHD
Y N Allergies to any Drugs
Y N Allergy to Latex/Metals
Y N Allergy 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 Tuberculosis (TB)
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

Please discuss any medical problem that your child has had:
____
____
____

Has your child ever experienced 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

Neighbor or Relative not living with you.

Name:______________ Phone # : (__)________

Address: ______________________________________
____

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 history.

I authorize the dental staff to perform the necessary dental services my child may need.

____
Signature of Parent/Guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

____
Signature of Parent/Guardian Date

If this office accepts insurance, I understand that I am responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

____
Signature of Parent/Guardian Date