Pearland Orthodontics

Practice Limited to Orthodontics and Dentofacial Orthopedics

Sheela Kudchadker, DDS, MS, PA

Welcome !

Your Smile Brightens Our Day!

Please fill out this form completely to the best of your ability. The better we communicate, the better we can care for you. All patient records are kept strictly confidential.

Today's Date _____

Tell Us About Your Child

Child's Name_____
Last First MI
Nickname_____ DOB _____/_____/_____

School _____Grade _____

Hobbies/Sports_____

Home # (_____)_____-_____

Home Address: _____

_____

Who Is Accompanying Your Child

Name_____ Relation_____

Do you have legal custody of this child Y_____ N_____

Whom may we thank for referring you?
_____

List brothers/sisters with age:_____
_____

Mother's Information:_____Step-Mom_____Guardian
Name_____ DOB_____/_____/_____
SS#_____ Email_____
Employer_____
Employer Address_____
_____

Occupation_____

Father's Information:_____Step-Dad_____Guardian
Name_____ DOB_____/_____/_____
SS#_____ Email_____
Employer_____
Employer Address_____
Occupation_____

Person Responsible for Account

Name_____ Relation _____

Billing Address _____
_____

Home #(____)_____-_____ Work#(_____)_____-_____

Employer_____

SS#_____-_____-_____ Email_____

Who is responsible for making appointments?

Name_____
Home #(_____)_____-_____ Wk #(____)_____-_____

Primary Orthodontic Insurance

Orthodontic Coverage? Y_____ N_____
Insurance Co. Name_____
Insurance Co. Phone #(____)_____-_____
Insurance Co. Address_____
_____
Group # (Plan, Local, or Policy)_____
Policy Holder's Name_____
Relationship to Patient_____
Policy Holder's DOB_____SS#_____
Policy Holder's Employer_____
Employer's Address_____
_____

Secondary Orthodontic Insurance

Orthodontic Coverage? Y_____ N_____
Insurance Co. Name_____
Insurance Co. Phone #(____)_____-_____
Insurance Co. Address_____
_____
Group # (Plan, Local, or Policy)_____
Policy Holder's Name_____
Relationship to Patient_____
Policy Holder's DOB_____SS#_____
Policy Holder's Employer_____
Employer's Address _____

CONTINUE ON BACK

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 Plastic
Y N Any hospital stays
Y N Any Operations
Y N Kidney/Liver Problems
Y N Psychological Counseling
Y N Congenital Heart Defect
Y N Rheumatic/Scarlet Fever
Y N Epilepsy/Seizures/Fainting
Y N Handicaps/Disabilities
Y N Heart Murmur/Prosthetic Valve/Prosthetic Hips
Y N Blood transfusion
Y N Hepatitis
Y N HIV+/AIDS
Y N Asthma
Y N Diabetes
Y N Cancer
Y N Arthritis
Y N Anemia
Y N Tuberculosis
Y N Hearing Impairment
Y N Hemophilia

Height:_____ Weight:_____

Please discuss any medical problem that your child has:
_____
_____

Child Physician_____
Does patient have tendency to colds? Y____ N_____
Sore throats? Y ___ N ____ Ear Infections? Y ____ N ____
Difficulty Breathing? Y ____ N ____
Is your child currently under the care of a physician?
Y ____ N ____ If yes, for what?_____
Has puberty begun? (boys and girls) Y ____ N ____
Has menstruation begun (girls) Y ____ N ____
Does your child need to take antibiotics before dental procedures?
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 any allergies your child has (medications, antibiotics, foods, Metals):_____
_____

Dental History

Child's Dentist _____
Last First
Phone #(_____)_____-_____
Date of Last Visit _____/_____/_____
Date of Last Dental X-Rays taken ___/____/____

What are the main concerns you would like for orthodontics to accomplish? _____
_____
Has your child ever had or been evaluated for orthodontic treatment before? Y_____ N _____

Has your child ever had an injury to his/her:
____Face ____Mouth ____Teeth ____ Chin

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 your child ever had any pain/tenderness/clicking/popping in his/her jaw joint (TMJ/TMD)?Y___ N____

Does your child brush his/her teeth daily? Y ___ N____
Floss his/her teeth daily? Y ____ N _____
Gums ever bleed? Y____ N _____

Does/did your child have any of the following habits?

Y N Clenching/Grinding Teeth
Y N Nursing Bottle Habits
Y N Speech Problems/Therapy
Y N Thumb/Finger Sucking
Y N Nail Biting
Y N Tongue Thrust
Y N Lip Biting
Y N Mouth Breather

Patient's Cooperation Level:
____ Excellent _____Good _____Fair ____Poor

I understand that the information 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 that my child may need.

_____
Signature of Parent or Guardian **Date**

I understand that I am responsible for full payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover.

_____
Signature of Parent or Guardian **Date**

Medical History Reviewed by_____
Sheela Kudchadker, DDS, MS, PA

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA as well as HIPPA privacy regulations.