

# Pearland Orthodontics

Practice Limited to Orthodontics and Dentofacial Orthopedics

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## 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 \_\_\_\_\_

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

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 Nail Biting

Y N Nursing Bottle Habits Y N Tongue Thrust

Y N Speech Problems/Therapy Y N Lip Biting

Y N Thumb/Finger Sucking 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 \_\_\_\_\_

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**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.**