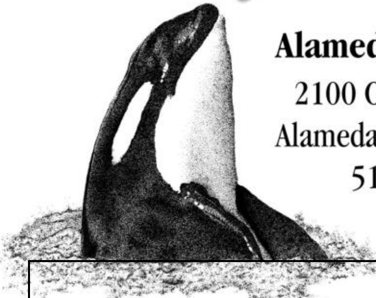
David W. Johnson, D.D.S.



Alameda Orthodontics
2100 Otis Drive, Suite F
Alameda, California 94501
510.521.4822

CHILD

PATIENT INFORMATION - CHILD or TEEN

Patient Name __________________ ____________________________ Age ________ Date of Birth___________________________
Address ____ Main Phone___________________________________
City, ST Zip ____
General Dentist's Name ____ and Phone____________________________________
How did you hear about our office?____
What is your main concern regarding the patient's teeth and jaws?____
____

MEDICAL HISTORY

Yes ☐ No ☐ Have the tonsils and/or adenoids been removed? If so, at what age? ____
Yes ☐ No ☐ Frequent colds or ear infections? Please describe ____
Yes ☐ No ☐ History of major illness? Please describe ____
Yes ☐ No ☐ Any drug sensitivities or allergies? Please describe____
Yes ☐ No ☐ Taking any medication now? Please list ____
Yes ☐ No ☐ Under medical care now? Please describe ____
Yes ☐ No ☐ Have you been vaccinated and tested for immunity to Hepatitis B (HBV)? Date ______________________________

Check any of the following for which you have been treated:

☐ Diabetes	☐ Asthma	☐ Prolonged bleeding
☐ Arthritis	☐ Epilepsy	☐ Nervous disorders
☐ Tonsillitis	☐ Hepatitis	☐ Rheumatic fever
☐ Brain injury	☐ Tuberculosis	☐ Heart condition
☐ Cancer	☐ AIDS or HIV	☐ Other ____________________

☐ **None of the above**

DENTAL HISTORY

Yes ☐ No ☐ Have there been any severe injuries to the face? Please describe ____
Yes ☐ No ☐ Are you aware of any missing permanent teeth? Which ones? ____
Yes ☐ No ☐ Has the patient ever sucked a thumb or fingers? If so, until what age?____
Yes ☐ No ☐ Does the patient breath predominantly through the mouth?
When did the patient last visit the dentist? ____

PERSONAL HISTORY

School ____ Grade ____
Hobbies or Special interests?____
Are there any siblings? Please give names & ages. ____
Is there any other information we should know? If so, please comment: ____
____

PLEASE COMPLETE THE NEXT PAGE ALSO

RESPONSIBLE PARTY INFORMATION

Name ______________________________ Marital Status__________
Residence ______________________________
Mailing Address if different ______________________________
Main phone ______________ Work Phone ______________
Birthdate ______________ Relationship to patient ______________
Employer______________ Employer Address______________
Spouse/Partner name ______________ Relationship to patient__________
Employer ______________ Employer Address______________
Birthdate __________ Main Phone__________ Work phone __________
Parent's home address and phone if not living with patient______________

DENTAL INSURANCE INFORMATION

To assist us in determining your financial arrangements, and because your insurance is a contract between you and your insurance company, please call your insurance carrier or benefits officer to verify this information BEFORE your appointment.

Insured's name __________Insured's Soc Sec or ID#__________Group/Local No. ______
Insurance Company ______________ Insurance Co. Address ______________
Insurance Co. Phone ______________ Insured's relationship to patient __________
Ortho Benefits ☐ No ☐ Yes %________ Lifetime Maximum Amount________Eligible now ☐ Yes ☐ No
Effective Date __________Are orthodontic records covered under general dental? ☐ Yes ☐ No
Does insurance carrier require additional claim forms after the initial claim form? ☐ Yes ☐ No
If yes, how often?__________
Do you have dual coverage? ☐ Yes ☐ No If yes, please complete the above information for the second insurance carrier on a separate piece of paper or below.

The above information is accurate to the best of my ability.

Signature ______________________________ Date ______________