

# Welcome to the office of Drs. Cassinelli, Shanker and Biddle

Our mission is to treat each individual with care, dignity and compassion, to base all treatment decisions on scientific knowledge, and to be evidence-based and patient-centered in all of our clinical care. Above all, our goal is to obtain excellence in all that we do.

## Tell Us About Your Child

### Child's Name

Today's Date \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Child's Nickname \_\_\_\_\_ Ethnicity \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  Male  Female

Child's Home # \_\_\_\_\_

### Child's Home Address \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_

Hobbies/Sports \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Physician \_\_\_\_\_

Other Family Members Treated by our office \_\_\_\_\_

From Whom did you first hear of our office? \_\_\_\_\_

### Mother's Information

Step Mother  Guardian

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Home # \_\_\_\_\_ Email \_\_\_\_\_

Home Address \_\_\_\_\_

APT/CONDO # \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Employer \_\_\_\_\_ Position \_\_\_\_\_

Wk # \_\_\_\_\_ Cell # \_\_\_\_\_

SS # \_\_\_\_\_ Do you have Orthodontic Insurance?  Yes  No

### Father's Information

Step Father  Guardian

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Home # \_\_\_\_\_ Email \_\_\_\_\_

Home Address \_\_\_\_\_

APT/CONDO # \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Employer \_\_\_\_\_ Position \_\_\_\_\_

Wk # \_\_\_\_\_ Cell # \_\_\_\_\_

SS # \_\_\_\_\_ Do you have Orthodontic Insurance?  Yes  No

Parent's Marital Status  Married  Divorced  Separated

Single  Widowed

**Person Responsible For Account**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Billing Address \_\_\_\_\_  
APT/CONDO # \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer \_\_\_\_\_ Position \_\_\_\_\_

Work # \_\_\_\_\_ SS # \_\_\_\_\_

I understand that I am responsible for payment of services rendered.

\_\_\_\_\_  
Signature of responsible party (This is typically the resident parent) Date

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

\_\_\_\_\_  
Signature of parent or guardian Date

**PLEASE COMPLETE THE DENTAL INSURANCE INFORMATION FORM IF YOU HAVE DENTAL INSURANCE WHICH HAS ORTHODONTIC COVERAGE**

If this office accepts insurance, I hereby authorize and direct payment of the dental/orthodontic benefits directly to this office.

\_\_\_\_\_  
Signature of Primary Insurance Owner Date

\_\_\_\_\_  
Signature of Secondary Insurance Owner Date

**Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home # \_\_\_\_\_ Wk # \_\_\_\_\_

Cell # \_\_\_\_\_

## Dental History

**The answers to the following questions are for office records only and will be considered confidential.**  
**A thorough and complete history is vital to a proper orthodontic evaluation.**

Yes No DK/U For the following questions mark Yes, No, or Don't Know/Understand.

- \_\_\_ \_\_\_ \_\_\_ Does patient have difficulty following directions?  
\_\_\_ \_\_\_ \_\_\_ Does patient have difficulty brushing his/her teeth conscientiously?  
\_\_\_ \_\_\_ \_\_\_ Does patient have a strong gag reflex?  
\_\_\_ \_\_\_ \_\_\_ Does patients have learning disabilities or need extra help with instructions?  
\_\_\_ \_\_\_ \_\_\_ Is patient sensitive, self-conscious?  
\_\_\_ \_\_\_ \_\_\_ Supernumerary (extra) or congenitally missing teeth?  
\_\_\_ \_\_\_ \_\_\_ Permanent or "extra" teeth removed?  
\_\_\_ \_\_\_ \_\_\_ Chipped or otherwise injured primary (baby) or permanent teeth?  
\_\_\_ \_\_\_ \_\_\_ Periodontal "Gum problems" or treated for periodontal problems?  
\_\_\_ \_\_\_ \_\_\_ Thumb, finger or sucking habit? Until age \_\_\_\_\_  
\_\_\_ \_\_\_ \_\_\_ History of speech problems?  
\_\_\_ \_\_\_ \_\_\_ Mouth breathing habit, snoring, difficulty in breathing?  
\_\_\_ \_\_\_ \_\_\_ Any relative with similar tooth or jaw relationships?  
\_\_\_ \_\_\_ \_\_\_ Onset of puberty?  
                    Females onset of menstruation (approximate date) \_\_\_\_\_  
                    Males onset of voice change (approximate date) \_\_\_\_\_  
\_\_\_ \_\_\_ \_\_\_ Has patient ever had a prior orthodontic examination or treatment?  
If so, when/where? \_\_\_\_\_  
  
\_\_\_ \_\_\_ \_\_\_ Would patient object to wearing orthodontic appliances (braces) should they be recommended?  
  
Date of most recent dental examination \_\_\_\_\_  
  
How often does patient brush? \_\_\_\_\_ Floss? \_\_\_\_\_  
  
What is the patient, parent or referral sources' primary concern?  
(What brought you here?)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? If so please list:

\_\_\_\_\_  
\_\_\_\_\_

### **Medical Alert Summary – Office Use Only**

\_\_\_\_\_  
\_\_\_\_\_

<p>Yes No DK/U (if yes please circle)</p> <p>___ ___ ___ Birth defects or hereditary problems?</p> <p>___ ___ ___ Rheumatoid or arthritic conditions?</p> <p>___ ___ ___ Endocrine or thyroid problems?</p> <p>___ ___ ___ Kidney problems?</p> <p>___ ___ ___ Diabetes?</p> <p>___ ___ ___ Cancer or been treated for a tumor?</p> <p>___ ___ ___ Stomach ulcer or hyperacidity?</p> <p>___ ___ ___ Polio, mono, tuberculosis, pneumonia?</p> <p>___ ___ ___ Problems of the immune system?</p> <p>___ ___ ___ AIDS or HIV positive?</p> <p>___ ___ ___ Sexually Transmitted Diseases?</p> <p>___ ___ ___ Hepatitis, jaundice or liver problem?</p> <p>___ ___ ___ Fainting spells, seizures, epilepsy or neurologic problem?</p> <p>___ ___ ___ Mental health or behavioral problem, including ADHD, bipolar, Depression?</p> <p>___ ___ ___ Vision, hearing, tasting or speech difficulties?</p> <p>___ ___ ___ Loss of weight recently, poor appetite?</p> <p>___ ___ ___ Excessive bleeding, black and blue tendency, anemia or bleeding disorders?</p> <p>___ ___ ___ High or low blood pressure?</p> <p>___ ___ ___ Tires easily?</p> <p>___ ___ ___ Chest pain, shortness of breath or swelling ankles?</p> <p>___ ___ ___ Cardiovascular problem (heart trouble), heart murmur, heart attack, angina, coronary insufficiency, stroke, inborn heart defects or rheumatic heart? If yes please list:</p> <p>_____</p> <p>_____</p> <p>___ ___ ___ Is premedication required for cardiovascular problem?</p> <p>___ ___ ___ Do you have a poor or altered diet?</p> <p>___ ___ ___ Frequent headaches, colds or sore throats?</p> <p>___ ___ ___ Eye, ear, nose or throat condition?</p> <p>___ ___ ___ Hayfever, sinus trouble, hives?</p> <p>___ ___ ___ Asthma?</p>	<p>Yes No DK/U (if yes please circle)</p> <p>___ ___ ___ Tonsil or adenoid conditions?</p> <p>___ ___ ___ Allergies or drug reactions?</p> <p>___ ___ ___ Known Drug Allergies.</p> <p>_____</p> <p>_____</p> <p>___ ___ ___ Are you taking medication, nutrient supplements or non-prescription medicine? Please list them:</p> <p>_____</p> <p>_____</p> <p>___ ___ ___ Do you or have you taken a Bisphosphonate* drug?</p> <p>___ ___ ___ Does the patient currently have or ever had a substance abuse problem?</p> <p>___ ___ ___ Operations? _____</p> <p>___ ___ ___ Hospitalized for: _____</p> <p>_____</p> <p>___ ___ ___ Other physical problems or symptoms? _____</p> <p>_____</p> <p>___ ___ ___ Being treated by another health care professional? For _____</p> <p>Date of latest physical exam? _____</p> <p>Weight _____ Height _____</p> <p><u>Medical History Update:</u> Indicate changes in pubertal status (voice change-boys, menstruation- girls)- please date &amp; initial onset: _____</p> <p>_____</p> <p>Any additional medical information we should be aware of that may impact treatment:</p> <p>_____</p> <p>_____</p> <p>I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes in my child's/or my own medical condition/history or dental status I will so inform this practice.</p> <p>_____</p> <p>Signature of parent or guardian _____ Date _____</p> <p>*Actonel, Boniva, Fosamax, Fosamax Plus D, Skelid, Didronel, Aredia, Zometa, or Bonafos</p>
--	--

Additional Comments/Explanations: