



Dr. Paul J. Styr, Inc.  
ORTHODONTICS

# Welcome

We would like to welcome you and your family to our office! Our goal is to make every visit pleasant and educational and provide the highest quality care and personal service possible. We know that the better we communicate with you, the better we can serve you... so please take a moment to complete this form in its entirety. Our goal is to work together with you to ensure your child has a beautiful smile that will last a lifetime.

## Tell Us About Your Child

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

**Child's Name:** \_\_\_\_\_  
LAST FIRST M.I.

Male  Female Nickname: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Child's Age: \_\_\_\_\_

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

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

**Child's Home Address:** \_\_\_\_\_  
CITY STATE ZIP

## Who is Accompanying Your Child Today?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have legal custody of this child:  Yes  No

Is your child adopted:  Yes  No

**Whom may we thank for referring you?** \_\_\_\_\_

List brothers/sisters with age: \_\_\_\_\_  
 \_\_\_\_\_

**General Dentist:** \_\_\_\_\_

Last visit date: \_\_\_\_\_

Parent's Marital Status:  Single  Married  Widowed  
 Divorced  Separated

## Mother's Information: Stepmother Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Work #: \_\_\_\_\_ Ext: \_\_\_ Home #: \_\_\_\_\_

Employer: \_\_\_\_\_

How long at current job: \_\_\_\_\_

SS#: \_\_\_\_\_ DL#: \_\_\_\_\_

## Father's Information: Stepfather Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Work #: \_\_\_\_\_ Ext: \_\_\_ Home #: \_\_\_\_\_

Employer: \_\_\_\_\_

How long at current job: \_\_\_\_\_

SS#: \_\_\_\_\_ DL#: \_\_\_\_\_

## Person Responsible For Account

Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
 \_\_\_\_\_  
CITY STATE ZIP

Previous Address: \_\_\_\_\_  
 \_\_\_\_\_  
CITY STATE ZIP

Work #: \_\_\_\_\_ Ext: \_\_\_ Home #: \_\_\_\_\_

Employer: \_\_\_\_\_

SS#: \_\_\_\_\_ DL#: \_\_\_\_\_

## Primary Dental/Orthodontic Insurance

Orthodontic Coverage:  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

**Policy Owner's Name:** \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Policy Owner's Birthdate:** \_\_\_ / \_\_\_ / \_\_\_

Policy Owner's SS#: \_\_\_\_\_

**Policy Owner's Employer:** \_\_\_\_\_

## Secondary Dental/Orthodontic Insurance

Orthodontic Coverage:  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

**Policy Owner's Name:** \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Policy Owner's Birthdate:** \_\_\_ / \_\_\_ / \_\_\_

Policy Owner's SS#: \_\_\_\_\_

**Policy Owner's Employer:** \_\_\_\_\_

**What are the main concerns you would like to have addressed with your child?**

\_\_\_\_\_

\_\_\_\_\_

Has your child ever had a serious/difficult problem associated with previous dental work?  Yes  No

Has your child ever been evaluated or had orthodontic treatment before?  Yes  No

Have there been any previous injuries to the face, mouth, teeth or chin?  Yes  No

List any musical instruments played: \_\_\_\_\_

Have adenoids or tonsils been removed?  Yes  No

Does your child have missing or extra teeth?  Yes  No

**Has your child ever had any pain or tenderness in jaw joints (TMJ/TMD)?**  Yes  No

Does your child brush his/her teeth daily?  Yes  No

Floss his/her teeth daily?  Yes  No

Child's Physician: \_\_\_\_\_

Phone#: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Is your child currently under the care of a physician  Yes  No

Has puberty begun?  Yes  No

Has menstruation begun? (girls)  Yes  No

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 that your child is allergic to:** \_\_\_\_\_

\_\_\_\_\_

**Has your child ever had any of the following medical problems?**

- |                              |                             |
|------------------------------|-----------------------------|
| Y N Abnormal Bleeding        | Y N Diabetes                |
| Y N Allergies to any drugs   | Y N Handicaps/Disabilities  |
| Y N Allergic to Latex/Metals | Y N Hearing Impairment      |
| Y N Allergic to Plastic      | Y N Heart Murmur            |
| Y N Any hospital stays       | Y N Hemophilia              |
| Y N Any operations           | Y N Hepatitis               |
| Y N Asthma                   | Y N HIV+ or AIDS            |
| Y N Cancer                   | Y N Kidney/Liver problems   |
| Y N Congenital Heart Defect  | Y N Rheumatic/Scarlet Fever |
| Y N Convulsions/Epilepsy     | Y N Tuberculosis (TB)       |

Please discuss any medical problems your child has had:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Does your child have any of the following habits?**

- |                              |                           |
|------------------------------|---------------------------|
| Y N Clenching/grinding teeth | Y N Nursing bottle habits |
| Y N Lip sucking/biting       | Y N Speech problems       |
| Y N Mouth breather           | Y N Thumb/finger sucking  |
| Y N Nail biting              | Y N Tongue Thrust         |

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

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

**Parent or Guardian Consent and Signature**

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 status or personal information.

I authorize the staff at Dr. Paul J. Styrk Orthodontics, Inc. to perform the necessary orthodontic or dental services my child may need.

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

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

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

**Medical History Update**

Has your child's medical history changed since your last visit?  Yes  No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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