Welcome to Sonneborn Orthodontics!

arthur a. sonneborn d.d.s.,ms

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Today's Date:_____

Male ☐ Female ☐

Child's Name:_____
LAST FIRST MI

Nickname:_____

Child's Birthdate:____/____/____ Child's Age:_____

Phone#:( )_____ Hobbies/Sports:_____

Child's Home Address:_____
APT/CONDO#

_____
CITY STATE ZIP

Who Is Accompanying Your Child Today?

Name:_____Relation:_____

Do you have legal custody of this child?
Yes ☐ No ☐

How did you hear about Dr. Sonneborn? Friends ☐
Radio ☐ Phonebook ☐ Dentist ☐ Billboard ☐ Ins Carrier ☐ TV ☐
Other _____ **Please check all that apply above**

List Brothers/Sisters and Age_____

General Dentist:_____

Last Visit Date:_____

Parent's Marital Status: ☐ Single ☐ Widowed
☐ Married ☐ Divorced ☐ Separated

Mother's Information:

Parent ☐ Guardian ☐

Name:_____Birthdate:____/___/___

Wk#:( )_____Ext:___Hm#:( )_____

Employer:_____

Employer Address:_____

_____
CITY STATE

Father's Information:

Parent ☐ Guardian ☐

Name:_____Birthdate:____/___/____

Wk#:( )_____Ext:___Hm#:( )_____

Employer:_____

Employer Address:_____

_____
CITY STATE ZIP

Tell us the main reason for your visit with us today

_____

_____

*What would you like to accomplish from your visit with us today :*_____

_____

Person Responsible For Account

Name:_____Relation:_____

Billing Address:_____

_____
CITY STATE ZIP

Hm#:( )_____Wk#:( )_____Ext:_____

SS#:_____

Employer:_____

Employer Address:_____

Orthodontic Insurance Coverage?

☐ *Yes* ☐ *No*

Primary Insurance:

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:( )_____

Group #(Plan, Local, or Policy#):_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's Birthdate:___/___/__SS#:_____

Policy Owner's ID #:_____

Secondary Insurance:

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:( )_____

Group #(Plan, Local, or Policy#):_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's Birthdate:___/___/___SS#:_____

Policy Owner's ID #:_____

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

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

List any musical instruments played:_____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has the child ever had any pain/ tenderness in his/her jaw joint (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 as puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Please describe your child's current physical health:

☐ Good ☐ Fair

Please list all drugs that your child is currently taking:____

_____

Please list all drugs/things 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 + / 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 that your child has had:

_____

_____

Does/did 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

Neighbor or Relative not living with you:

Name:_____Phone#:( )_____

Address:_____

_____

CITY STATE ZIP

I understand that the information that I have given is correct to the best of my knowledge, that I 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 orthodontic staff to perform the necessary orthodontic 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 services of one or more credit reporting services.

_____

Signature of parent or guardian Date

The Parent or Guardian who signs the Contract is Solely responsible for payment. Thank You

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