Pinole Valley
ORTHODONTICS
DR. KAMILAH SANFORD

2830 Pinole Valley Rd. Ste C --- Pinole, CA, 94564 --- PH # (510) 275-3200

MUST ANSWER QUESTIONS WITH **

**1. TELL US ABOUT YOUR CHILD

Name:____
First Mi Last

Nickname:____________________________________

Birthdate:________________Gender:___________

Address:_____________________________________

____
City State Zip

PREFERED LANGUAGE: ____________________

School: ___________________________

Hobbies/Sports:______________________________

Who may we thank for referring?

____

Other family members seen by us?

____

**2. RESPONSIBLE PARTY INFORMATION

Name:____
First Mi Last

Birthdate: ______________Gender:___________

❒ Single ❒ Separated
❒ Widowed
❒ Married ❒ Divorced

Relationship to Child:__________________

Do you have legal custody? ❒ Yes ❒ No

Phone # ______________________________

Alternate # ______________________________

Email: ____________________________________

Address (if different from child)

____

____
City State Zip

3. INSURANCE

Insurance Co: _________________________________

Member ID # or SSN ______________________

Group # __________________________

Ph # ______________________________

Insured's Name:__________________________

Birthdate: ___________________________

*Employer:____________________________

Relationship to Child:__________________

Address (if different from child)

____

**4. EMERGENCY CONTACT

Name:____
First Mi Last

Birthdate:________________Gender:___________

Relationship to Child:____________________

Do they have legal custody? ❒ Yes ❒ No

Phone # _______________________________________

Email: ____

Address (if different from child)

____

____
City State Zip

5. MEDICAL HISTORY

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**Child's Physician: ____________________

Phone #: _________________________

Last visit: ________________________

Has puberty begun? ❒ Yes ❒ No

Has menstruation begun? (Girls) ❒ Yes ❒ No

Is your child currently under care of a physician? ❒ Yes ❒ No

Please list your child's current medications:

____

Please list your child's current allergies:

____

***Does or has your child ever had any of the following diseases/medical conditions?*

❒ Yes ❒ No Abnormal bleeding
❒ Yes ❒ No ADD / ADHD
❒ Yes ❒ No Anemia
❒ Yes ❒ No Anxiety
❒ Yes ❒ No Asthma
❒ Yes ❒ No Autism
❒ Yes ❒ No Blood Transfusions
❒ Yes ❒ No Cancer/Chemotherapy
❒ Yes ❒ No Congenital Heart Defect
❒ Yes ❒ No Depression
❒ Yes ❒ No Diabetes
❒ Yes ❒ No Difficulty Breathing
❒ Yes ❒ No Eating Disorder
❒ Yes ❒ No Epilepsy/Seizure/Fainting
❒ Yes ❒ No Fever Blisters
❒ Yes ❒ No Heart Murmur
❒ Yes ❒ No Handicapped/Disability
❒ Yes ❒ No Hepatitis
❒ Yes ❒ No Hearing Impairment
❒ Yes ❒ No HIV +/AIDS
❒ Yes ❒ No Hospitalized for any reason
❒ Yes ❒ No HPV
❒ Yes ❒ No Kidney Problems
❒ Yes ❒ No Psychiatric Problems
❒ Yes ❒ No Rheumatic/Scarlet Fever
❒ Yes ❒ No Severe/Frequent Headaches
❒ Yes ❒ No Shingles
❒ Yes ❒ No Sinus Problems
❒ Yes ❒ No Ulcers
❒ Yes ❒ No Tuberculosis

Please list any other applicable serious medical condition(s) that your child has or has had:

____

***Is your child allergic to any of the following?*

Aspirin	❒ Yes ❒ No
Codeine	❒ Yes ❒ No
Latex	❒ Yes ❒ No
Metal/Plastic	❒ Yes ❒ No
Penicillin	❒ Yes ❒ No
Dental Anesthetics	❒ Yes ❒ No

Health History Update:

6 mo:________________ IN. _____

12 mo:________________ IN. _____

18 mo:________________ IN. _____

24 mo:________________ IN. _____

30 mo:________________ IN. _____

6. DENTAL HISTORY

**General Dentist:__________________

Last Cleaning: ____________________

Any treatment pending? Y / N

Does your child brush daily? ❒ Yes ❒ No

Does your child floss daily? ❒ Yes ❒ No

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What are the main concerns that you would like orthodontics to accomplish for your child?

____

Has your child had an orthodontic consultation or ortho treatment before? ❒ Yes ❒ No

If so, when and where?

____

***Does your child have or had any of the following?*

Injuries to face/chin	❒ Yes ❒ No
Injuries to mouth/teeth	❒ Yes ❒ No
Missing permanent teeth	❒ Yes ❒ No
Extra permanent teeth	❒ Yes ❒ No
Jaw pain/discomfort	❒ Yes ❒ No
Jaw clicking/locking	❒ Yes ❒ No
Speech Problems	❒ Yes ❒ No

Does your child have any of the following habits?

Thumb/finger sucking	❒ Yes ❒ No
Nail biting	❒ Yes ❒ No
Grinding/clenching	❒ Yes ❒ No
Chewing on ice/objects	❒ Yes ❒ No
Tongue thrusting	❒ Yes ❒ No
Mouth breather	❒ Yes ❒ No

****I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent*

____
Parent/Guardian Signature Date

____
Orthodontist Signature Date

***7. CONSENT FOR ORTHODONTIC RECORDS

I understand that photographs, x-rays, will be taken during the course of my examination, treatment, and follow up care. Records will be taken in the beginning, middle, and end of orthodontic treatment.

____
Parent Signature Date

**8. HIPAA

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

____
Parent Signature Date

**9. CONSENT TO TREAT A MINOR

I hereby give Pinole Valley Orthodontics and staff permission to treat my child while I am not present.

____
Parent Signature Date

The party listed below has my permission to make decisions regarding my child's dental treatment, medical treatment (if necessary should an emergency arise), and behavior management. Party below may also bring my child to orthodontic appointments and discuss treatment and account with the doctor and staff.

Authorized Party: ____________________

Relationship to Child: ________________

Phone #: ______________________

____
Parent Signature Date