Date:________________

Patient's Name:_________________________ _________________________ _____
Last First M.

Age: ______ Birth Date:______ ______ ______ Gender:
MO DAY YR Male Female Non-Binary

Email Address: ________________________________ Mobile #: ________________

Address: ____________________________ __________________ ________________
Street Number & Name City Zip Code

Employer: ________________________________ Phone#:_____________________
Company Name/Occupation

Current Dentist:_______________________ Referred By:______________________

PARENT/GUARDIAN INFORMATION (MINORS ONLY):

Father: ____
Name Street Address City Zip

Email Address: ________________________________ Mobile #: ________________

Employer: ________________________________ Phone#:_____________________
Company Name/Occupation

Mother:____
Name Street Address City Zip

Email Address: ________________________________ Mobile #: ________________

Employer: ________________________________ Phone#:_____________________
Company Name/Occupation

Single Married Separated Divorced

Names & Ages of Other Children in Family: ____________________________________

Responsible Party (For Financial Contract): __________________________________
Address: ____________________________ __________________ ________________
Street Number & Name City/Zip Phone #

Kidshine Orthodontics

MEDICAL HISTORY

Is the patient in good health? YES NO ______________________________
Patient's Physician

Check any of the following for which the patient has been treated:

Diabetes.............
Pneumonia.........
Heart Disease....
Rheumatic Fever ....
Bone Disorders.........
Glaucoma..........
Tuberculosis.......

Anemia........
Epilepsy........
Asthma.......
Kidney Disease.....
Hepatitis.......
Endocrine Problems....

Prolonged Bleeding...
Fainting/Dizziness.....
Nervous Disorders......
Liver Disease ....
Other.......

List any drugs/medications that are now being taken: ______________________________

____ None

List any allergies or drug sensitivity: ______________________________________

____ None

Have there been any injuries to the face, mouth, or teeth?

Has the patient ever sucked a thumb or fingers? Yes No

If yes, until what age? ___________

Does the patient have any speech problems? Yes No

Reason for consultation: ______________________________________

KIDSHINE Orthodontics

INSURANCE INFORMATION

Social Security #: (Minors only) ______________________ ________________________

Mother SSN Father SSN

Patient SSN: ______________________

Insurance Carrier: ______________________________ Group #:____________________

Subscriber Info: _______________________ _________________ Policy #:____________

Name Birth date

Additional Insurance Carrier: _________________________Group#:_________________

Subscriber Info: _____________________ ________________ Policy #:_______________

Name Birth date

Additional Insurance Carrier: _________________________Group#:_________________

Subscriber Info: _____________________ ________________ Policy #:_______________

Name Birth date

Photo/Video Release Form

The greatest thank you we can get from you is by letting others know about your experience with us. We would like to share your photo/video testimony about your remarkable visit.

I grant KidShine Orthodontics the unlimited right to use photographs and video testimonies for marketing and educational activities connected with Kidshine Orthodontics. I understand that by signing this release that I waive any and all present or future compensation rights for the use of the above stated material.

Patient Name: ____

Parent Signature (Minors only): ______________________________

Patient Signature: ____

Date: ____