Charles J. Boettcher, DDS - 3/6/2024

Patient Name

First Name	Last Name

Step 1

About Your Child

Today's Date:	Child's Name:	Child's Nickname:	Gender
Child's Birthdate:	Age:	School:	Grade:
Child's Home Phone#:	Child's SS#:	Child's Address:	City:
State:	Zip:	Referred By: (If doctor, please give address & phone number.)	

Primary Dental Insurance

Do you have Primary Dental Insurance?

Co. Name:	Address:	City	State
Zip	Phone #:	Insured's ID#:	
Group# (Plan, Local, or Policy#):		Insured's Name:	Relation:
Date of Birth:	Insured's Employer:	Relation:	Date of Birth:
Insured's Employer:		Does either policy cover Orthodontics?	

Secondary Dental Insurance

Do you have Secondary Dental Insurance?

Co. Name:	Address:	City	State
Zip	Phone #:	Insured's ID#:	
Group# (Plan, Local, or Policy#):		Insured's Name:	Relation:
Date of Birth:	Insured's Employer:	Relation:	Date of Birth:
Insured's Employer:		Does either policy cover Orthodontics?	

Step 2

Child's Family Information

Who is accompanying this child today? (Full Name)		Relation To Child	Do you have Legal Custody of this Child?
How many Brothers/Sisters?		Age(s):	
Mother's/Step Mother/Guardian Name:		CHECK IF SAME AS CHILD'S	Home Address
City	State	Zip	Home Phone #:
Work Phone #:	EXT	Mother's/Step Mother/Guardian Social Security#	
Date Of Birth	Mother's/Step Mother/Guardian Driver Lic. #		Employer
How Long?	Employer's Address	City	State
Zip	Father's Name/Step Father/Guardian:		CHECK IF SAME AS CHILD'S
Home Address	City	State	Zip
Home Phone #	Work Phone #	EXT	
Father's/Step Father/Guardian Social Security#		Date Of Birth	
Father/Step Father/Guardian Driver Lic. #		Employer:	How Long?
Employer's Address	City	State	Zip

Step 3

Account Information

Person ultimately responsible for account

Name	Relation To Child	Billing Address	City
State	Zip	Social Security#	Date Of Birth
Drivers L.C. #	Work Phone #	EXT	Cell Phone #
Payment method:		Enter card # above (if accepted)	

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials

Step 4

Child's Dental Information

Reason for today's visit:	Is Child in pain?

Please indicate any of the following problems:

Discomfort, clicking or popping in jaw.	Lost/Broken Filling(s)	Stained teeth	Red, swollen or bleeding gums.
Teeth grinding	Locking Jaw	Sensitive tooth, teeth or gums.	Ringing in Ears
Bad breath	Blisters/Sores in or around the mouth.	Broken/Chipped tooth	Loose tooth
Other(s):	Does child require pre-medication?		Previous Dentist:

Last Dental X-rays:	Times a day child brushes?
Times a week child flosses?	Is the child's water fluoridated?
How would you rate the child's smile?	

Child's Medical History

Is Child taking any of the following medications?

Pain killers (Including Aspirin)	Ritalin	Stimulants	Blood Thinners
Tranquilizers	Insulin	Muscle relaxers	Others:
Child's Physician:	Phone #	Address	City

State	Zip	Last Medical Exam:

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Heart Murmur	Rheumatic fever	Artificial Heart Valves	Congenital Heart defect
Scarlet Fever	Surgeries/Operations	Cancer/Tumors	Chemotherapy
Jaw Problems TMJ/TMD	Hearing Problems	Tonsillitis	Respiratory Problems
Asthma/Difficulty Breathing	Blood Transfusion(s)	Leukemia/Anemia	Diabetes/Hypoglycemia
Hemophilia/Abnormal Bleeding	High/Low Blood Pressure	Cleft Lip/Palate	Birth Defects
Chicken Pox	Hepatitis	Artificial Bones/Joints/Implants	Liver/Kidney/Organ Problems
HIV+/AIDS/ARC	Tuberculosis TB	Psychiatric Problems	Hyper Active/ADD
Fainting/Seizures/Epilepsy	Cerebral Palsy	Please list any other medical condition(s) child has or ever had:	

Is Child allergic to:

Latex	Penicillin/Amoxicillin	Tetracycline	Dental Anesthetics (Novocaine)
Aspirin		Food allergies	
Other(s):			

Please rate the child's general health from 1-10:	Does child wear contact lenses?	Has this teen ever taken the drug Ritalin?

Child's Blood type:

Does this teen do any of the following?

Thumb/Finger Sucking	Tongue Thrusting/Sucking	Heavy Snoring	Mouth Breathing
Lip Sucking/Biting			

Step 5

Authorization

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

Signature

Date