BOHL&RACE
Orthodontics S.C.

Date ____________

Child /Adolescent Information

Patient Name ______________________________
Last First Middle

Nickname ____________ Date of Birth ____________ Age ______ Male ○ Female ○

Home Address ______________________________
Street City State ZIP

Home Phone (_____) ______________________________

Responsible Party Information

Name ______________________________
Last First Middle

Relationship Parent ○ Step-parent ○ Grandparent ○ Other ○ ____________

Date of Birth ____________ SS#: ____________ E-mail ____________

Marital Status Single ○ Married ○ Divorced ○ Home Phone (_____) ____________

Home Address ______________________________
Street City State ZIP

Previous Address ______________________________
(if less than 3 years) Street City State ZIP

Employer ____________ Employer Phone (_____) ____________

How long at present Employer? ____________ Job Title ____________

Responsible Party

Spouse Information ○ Parent ○ Step-Parent

Spouse's Name ______________________________
Last First Middle

Date of Birth ____________ SS#: ____________

Employer ____________ Employer Phone (_____) ____________

How long at present Employer? ____________ Job Title ____________

Whom may we thank for referring you to our office? ____________

Primary Dental Insurance

Orthodontic Coverage Yes ○ No ○

Insurance Company Name ____________

Insurance Company Address ____________

City ____________

State ____________ Zip ____________

Insurance Co. Phone (_____) ____________

Policy Holder's Name ____________

Relationship to Policy Holder ____________

Group # ____________

Policy Holder's Date of Birth ____________

Policy Holder's S.S.# or ID# ____________

Policy Holder's Employer ____________

Secondary Dental Insurance

Orthodontic Coverage Yes ○ No ○

Insurance Company Name ____________

Insurance Company Address ____________

City ____________

State ____________ Zip ____________

Insurance Co. Phone (_____) ____________

Policy Holder's Name ____________

Relationship to Policy Holder ____________

Group # ____________

Policy Holder's Date of Birth ____________

Policy Holder's S.S.# or ID# ____________

Policy Holder's Employer ____________

Release

I authorize Dr. Charles F. Bohl & Dr. Kevin T. Race to perform diagnostic procedures and treatments as may be necessary for orthodontic care. I certify that I am the legal guardian for the above named patient.

Legal Guardian Signature ____________ Date ____________

Updated Legal Guardian Signature ____________ Date ____________

Print Name ____________

This office reserves the right to verify the credit status of the responsible parties prior to extending credit for treatment fees. I hereby authorize OrthoBanc, LLC, on behalf of Bohl & Race Orthodontics to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options. I hereby authorize and assign payment of insurance benefits directly to Bohl & Race Orthodontics, S.C. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of orthodontic treatment including insurance co-payment and any balance not paid by insurance.

Responsible Party Signature ____________ Date ____________

Updated Repsonsible Party Signature ____________ Date ____________

Print Name ____________

BOHL&RACE
Orthodontics S.C.

Child /Adolescent History

Patient Name ______________________________ **Date** ____________
Last First Middle

Nickname ______________________ Date of Birth ______________________

**Please circle Y (yes) or N (no) for the following questions. Your answers are for our records only and will be considered confidential. Please use the space after the question for additional explanations.

Medical History

Y N Is the patient in excellent health? ____________

Y N Has there been any change in the patient's health within the last year? ____________

Last physical exam was (month/year)____________

Y N Is the patient now under the care of a physician? If so, what is being treated? ____________

Y N Has the patient had a serious illness/hospitalization in the past 5 years? ____________

Y N Is the patient taking any medication (incl. non-prescription)? ____________

Y N Is the patient taking or has the patient taken Bisphosphonates (Fosamax, Aredia, etc.) in the past five years?

Does the patient have any of the following conditions?

Allergies or drug reactions to:

- Y N Latex
- Y N Penicillin or other antibiotics
- Y N Sulfa drugs
- Y N Aspirin, Ibuprofen, Tylenol
- Y N Local anesthetics
- Y N Codeine or other narcotics
- Y N Other ____________

Y N Respiratory problems, emphysema
Y N Asthma or hay fever
Y N Sinus trouble
Y N Persistent swollen neck glands
Y N Thyroid or endocrine problems
Y N Diabetes
Y N Hepatitis, jaundice or liver disease
Y N AIDS or HIV infection
Y N Sexually transmitted disease
Y N Substance abuse problem (past or present)
Y N Mental health problem or nervous disorder
Y N Epilepsy or other neurological disease
Y N Fainting spells or seizures
Y N Blood disorder such as anemia
Y N Do you smoke?
Y N Abnormal bleeding or blood transfusion
Y N Low blood pressure
Y N Cardiovascular disease (heart trouble, heart attack, angina, high blood pressure, arteriosclerosis, stroke)
Y N Damaged or artificial heart valves, including heart murmur or rheumatic heart disease
Y N Arthritis or joint problems or artificial joints/limbs
Y N Require pre-medication before dental visits?
Y N Birth Defects
Y N Kidney Trouble
Y N Tuberculosis
Y N Bone fractures or trauma to face or jaw
Y N Vision, hearing or speech difficulty
Y N Persistent Cough
Y N Frequent colds or sore throats
Y N Frequent headaches
Y N Stomach ulcer or hyperacidity
Y N Tumor (Cancerous or benign)
Y N Radiation therapy or Chemotherapy
Y N Tonsils or adenoids removed? What age? ________
Y N Is there a problem with abnormal height or weight?
Y N **Females:** Are you pregnant?

Y N Does the patient have any disease, condition or problem not listed above that you think we should know about? If so, please explain ____________

Dental History

Name of patient's dentist____________ Date of last dental exam ____________(month/year)

Y N Chipped or injured permanent teeth
Y N Teeth sensitive to hot or cold
Y N Jaw fractures, cysts, mouth infections
Y N Previous root canal therapy
Y N Bleeding gums or bad taste/mouth odor
Y N Other periodontal (gum) problems
Y N Problems with food trapped between teeth
Y N History of missing or extra teeth
Y N Have any permanent teeth been removed?
Y N Have wisdom teeth been removed?
Y N Teeth that irritate tongue, cheek, lip, etc.
Y N Previous orthodontic treatment or retainer
Y N Previous periodontal (gum) treatment
Y N Numerous fillings

(over)

BOHL&RACE
Orthodontics S.C.

Child / Adolescent History continued

Patient Name ____
Last First Middle

Dental History (continued)

Y N Frequent canker sores or cold sores
Y N Mouth breathing habit or snoring troubles
Y N Abnormal swallowing (tongue thrust)
Y N Has there been a negative dental experience?
Y N Is the diet high in sweets/sugars?
Y N Damaged restorations or fillings
Y N Thumb or finger habit as a child
Y N Loose or shifting teeth
Y N Is there dental work necessary at this time?

TMJ History

Y N Is there a history of jaw joint problems?
Y N Is pain experienced in either jaw joint?
Y N Has the jaw ever locked?
Y N Is there a history of clenching the teeth?
Y N Is there a history of grinding the teeth?
Y N Is clicking or popping noticed in either jaw joint?

The Deciduous (Baby) Teeth came in ○ Early ○ Average ○ Late
The Deciduous (Baby) Teeth were lost ○ Early ○ Average ○ Late
The patient most resembles ○ Mother ○ Father ○ Both ○ Neither
Is the patient adopted? ○ Yes ○ No

What Are Your or Your Dentist's Concerns?

Please check as appropriate

Teeth

○ Straighten the front teeth **upper / lower**
○ Straighten the back teeth **upper / lower**
○ Move upper teeth **forward / backward**
○ Move lower teeth **forward / backward**
○ Eliminate crowding of teeth **upper / lower**
○ Eliminate spaces between teeth **upper / lower**
○ Make the line of upper teeth more level
○ Other ____

Face

○ Move upper lip **forward / backward**
○ Move lower lip **forward / backward**
○ Show **more / less** of teeth when smiling
○ Show **more / less** of gums when smiling
○ Reduce the strain in **chin / lips** when lips close
○ Make profile of the nose **longer / shorter**
○ Get rid of sag under lower jaw
○ Move chin **forward / backward**
○ Move chin **left / right**
○ Other ____

Help Us to Get to Know You Better

School ____________________ Grade ________ Favorite Class ____________________
Hobbies, Sports, Upcoming Events ____
How many Brothers? __________ Ages __________ Sisters? __________ Ages __________

**I certify that I have read and understand the above. I acknowledge that I have completed this form to my best knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.
If there are any changes later to this history record or medical or dental status, I will inform the practice.

Legal Guardian Signature ____________________ Date ____________________

Updated Legal Guardian Signature ____________ Date ________ Updated Legal Guardian Signature ____________ Date ________

Updated Legal Guardian Signature ____________ Date ________ Updated Legal Guardian Signature ____________ Date ________

Updated Legal Guardian Signature ____________ Date ________ Updated Legal Guardian Signature ____________ Date ________