CRANE & SEAGER ORTHODONTICS

FORT COLLINS
4144 Timberline Road
(970) 226-6443

LOVELAND
3520 E. 15th Street • Suite 101
(970) 226-6443

WELCOME TO CRANE & SEAGER ORTHODONTICS

Making A Difference, One Smile At A Time

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. Please fill out this form completely so we can best care for you.

1 TELL US ABOUT YOUR CHILD

Today's Date: ____________________

Email Address: ____

May We Email You With Special Offers, Exclusive Events & Contests: ☐ Yes ☐ No

Child's Name: ____

Nickname: ______________________________ ☐ Male ☐ Female
CHILD PREFERS TO BE CALLED

Birthdate: ____ /____ /____ Age: ______

School: ______________________________ Grade: __________

Hobbies: ____

Sports Teams My Child Plays On: ______________________________

Organizations My Child Is Involved With: ______________________________

Child's Home Address: ______________________________
APT/CONDO #

____
CITY STATE ZIP

Hm #: (____) ____________ Cell/Other #: (____) ____________

2 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: ______________________________ Relation: __________

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

Whom may we thank for referring you to us? ____________________

List brothers/sisters with age: ______________________________

____

General Dentist: ____

Child's Last Visit Date: ______________________________

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

3 PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: ______________________________ Relation: __________

Billing Address: ______________________________
APT/CONDO #

____
CITY STATE ZIP

Hm #: (____) ____________ DL #: ____________

Cell #: (____) ____________ SS #: ____________

Employer: ____________ Wk #: (____) ____________ Ext. ______

4 PARENT/GUARDIAN INFORMATION

☐ **Mother's Information** ☐ Step Mother ☐ Guardian

Name: ______________________ Birthdate: ____ /____ /____

Email Address: ____

May We Email You With Special Offers, Exclusive Events & Contests: ☐ Yes ☐ No

Cell #: (____) ____________ Hm #: (____) ____________

Employer: ____________ Wk #: (____) ____________

☐ **Father's Information** ☐ Step Father ☐ Guardian

Name: ______________________ Birthdate: ____ /____ /____

Email Address: ____

May We Email You With Special Offers, Exclusive Events & Contests: ☐ Yes ☐ No

Cell #: (____) ____________ Hm #: (____) ____________

Employer: ____________ Wk #: (____) ____________

5 ORTHODONTIC INSURANCE

PRIMARY ORTHODONTIC INSURANCE INFORMATION

Orthodontic Coverage: ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: (_____) ____________

Member ID # or Policy #: ______________________________

Insured's Name: ____________________ Relation: __________

Insured's Birthdate: ____ /____ /____ **Insured's** ID#: ____________

Insured's Employer: ______________________________

SECONDARY ORTHODONTIC INSURANCE INFORMATION

Orthodontic Coverage: ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: (_____) ____________

Member ID # or Policy #: ______________________________

Insured's Name: ____________________ Relation: __________

Insured's Birthdate: ____ /____ /____ **Insured's** ID#: ____________

Insured's Employer: ______________________________

CONTINUED ON BACK

4 CHILD'S MEDICAL HISTORY

Your child's physical health is: ☐ Good ☐ Fair ☐ Poor

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

Please explain: ____________________

____

Child's Physician: ____________________

Phone #: (____) ____________ Date of Last Visit: ____________

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Have you ever had any of the following diseases or medical conditions?

Y	N	Abnormal Bleeding	Y	N	Hearing Impairment
Y	N	ADD/ADHD	Y	N	Heart Murmur
Y	N	Any Operations	Y	N	Hemophilia
Y	N	Artificial Bones/Joints/Valves	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+/AIDS
Y	N	Blood Transfusion	Y	N	Hospitalized for Any Reason
Y	N	Cancer	Y	N	Kidney/Liver Problems
Y	N	Congenital Heart Defect	Y	N	Lupus
Y	N	Diabetes	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy/Seizures/Fainting	Y	N	Sickle Cell Disease/Traits
Y	N	Handicaps/Disabilities	Y	N	Tuberculosis (TB)

Please discuss any medical problems your child has had:

____

____

____

Please list all drugs that your child is currently taking:

____

Are you allergic to any of the following:

Y	N	Dental Anesthetics	Y	N	Aspirin	Y	N	Penicillin
Y	N	Any Metals/Plastics	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that your child is allergic to:

____

____

____

5 CHILD'S DENTAL HISTORY

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

____

____

____

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

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

List any musical instruments played: ☐ Yes ☐ No

Have adenoids or tonsils been removed? ☐ Yes ☐ No

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

Has your 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

Does/did your child have any of the following habits?

Y	N	Clenching/Grinding Teeth	Y	N	Nursing Bottle
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

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.

____

Signature of Parent or Guardian Date

Thank You for filling out this form completely.

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 the office, use the services of one or more credit reporting services.

____

Signature of Parent or Guardian Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

____

Signature of Parent or Guardian Date

Our Office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. **Initials:** ____________ **Date:** ____________

Doctor's Comments: ____________________

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