



Date _____

TELL US ABOUT YOUR CHILD

Patient's Name _____ Prefers to be called _____
First Middle Last

Address _____
Street City Zip

Home Phone (____) _____ - _____ Email _____

Date of Birth _____ Male Female Age _____

School _____ Grade _____ Hobbies/Sports _____

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

Patient lives with: Both Parents Mother Father Other: _____

PARENTAL INFORMATION

Father Stepfather Guardian Name _____
First Middle Last

Address _____
Street City Zip

Phone: Home (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____

Employer: _____ Occupation: _____

Email: _____

Mother Stepmother Guardian Name _____
First Middle Last

Address _____
Street City Zip

Phone: Home (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____

Employer: _____ Occupation: _____

Email: _____

RESPONSIBLE PARTY INFORMATION

Same as Above
Responsible Party Name _____ Relation _____
First Middle Last

Address _____
Street City Zip

Phone: Home (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____

Employer: _____ Occupation: _____

Email: _____

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Name _____ Relationship to patient _____

Date of Birth _____ Social Security Number _____

Insurance Company _____ Group No _____ Local No _____

Insurance Company Address _____ Phone No _____
Street City Zip

Do you have dual coverage? Yes No

Insured's Name _____ Relationship to patient _____

Date of Birth _____ Social Security Number _____

Insurance Company _____ Group No _____ Local No _____

Insurance Company Address _____ Phone No _____
Street City Zip

814 Pierremont Rd. 129 East 5th St. (318) 861-0700
Shreveport, LA 71106 Natchitoches, LA 71457 Fax: (318) 868-2468

www.GeauxSmile.com

HEALTH HISTORY

(please check if patient has condition or received treatment)

- | | | |
|--|--|---|
| <input type="checkbox"/> ADD/ADHD/Behavioral Issues | <input type="checkbox"/> Blood Disorder/Anemia | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> AIDS/HIV Infection | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Murmur |
| <input type="checkbox"/> Allergy (Food, Drug or Other) | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Chest Pain/Angina |
| Food _____ | <input type="checkbox"/> Diabetes or Hypoglycemia | <input type="checkbox"/> High/Low Blood Pressure |
| Drug _____ | <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Latex/plastic Allergy |
| Other _____ | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Metals/Nickel Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eye/Hearing/Speech Impairment | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Artificial Joints/Valves | <input type="checkbox"/> Handicap/Disabilities | <input type="checkbox"/> Rheumatic |
| Fever/Disease | | |
| <input type="checkbox"/> Asthma/Breathing Problems | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Seizures/Stroke/Epilepsy |
| <input type="checkbox"/> Bone Disorder/Bisphosphonates | <input type="checkbox"/> Herpes | <input type="checkbox"/> Tuberculosis |

Other Condition (s) not listed _____

Please explain all checked responses _____

List any medications _____

Family Physician _____ Phone (____) _____ - _____ Date of Last Visit _____

For Female: Age of first menstrual cycle _____ Is the patient pregnant? _____

For Male: Age puberty started _____

DENTAL HISTORY

(please check if patient has condition or received treatment)

- | | |
|---|---|
| Dentist _____ | Date of last cleaning/visit _____ |
| <input type="checkbox"/> Any injuries to face, mouth or teeth | <input type="checkbox"/> Any clenching/grinding of teeth |
| <input type="checkbox"/> Thumb, finger or lip sucking habit | <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Both |
| <input type="checkbox"/> continuing <input type="checkbox"/> discontinued | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Tonsils removed | <input type="checkbox"/> Adenoids removed |
| When _____ | When _____ |
| <input type="checkbox"/> Mouth breathing when asleep, awake | <input type="checkbox"/> Any pain, popping or locking on opening |
| <input type="checkbox"/> Any known missing permanent teeth | or closing jaw movement |
| <input type="checkbox"/> Any known extra permanent teeth | <input type="checkbox"/> Any muscle tenderness or stiffness in jaw |
| <input type="checkbox"/> Any teeth removed by extraction | or neck area |
| When _____ | <input type="checkbox"/> Any ringing in ear or dizziness |
| <input type="checkbox"/> Is there a tongue thrust problem | <input type="checkbox"/> Any previous treatment of TMJ problems |
| <input type="checkbox"/> Musical Instrument _____ | <input type="checkbox"/> Snores or breathes heavily when sleeping |

Please explain all checked responses or any additional comments _____

Please list your chief concern(s) and what you would like your orthodontic treatment to accomplish _____

Have you ever been evaluated or treated by any orthodontist? If yes, complete below.

Orthodontist _____ Date last seen _____

Address _____

Type of treatment _____

RELEASE

I understand that the information that I have given is correct to the best of my knowledge, that it will be held to the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need.

Responsible Party Signature _____ 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 deductible that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

Responsible Party Signature _____ Date _____

I understand that the patient's records may be used for educational or promotional purposes.

Responsible Party Signature _____ Date _____