



# ROSENBERG ORTHODONTICS, PC

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## Orthodontic Specialists

55 Town Line Rd., Wethersfield, CT 06109  
(860) 529-9555

21 North Main St., West Hartford, CT 06107  
(860) 236-1199

227 Albany Tpke., Canton, CT 06019  
(860) 693-1919

435 Willard Ave., Newington, CT 06111  
(860) 666-2009

## PATIENT INFORMATION for CHILD

Child's Name	Nickname	Age	Date of Birth	Sex
Home Address			Town/Zip code	Home Phone
Mother's name	Address	Social Security #:		Home Phone
Mother's employer	Address	Town/Zip code		Work Phone
Father's name	Address	Social Security #:		Home Phone
Father's employer	Address	Town/Zip code		Work Phone
Mother's Cell and Email:		Father's Cell and Email:		
Names & ages of brothers & sisters				
Child's Dentist	Town/Zip code		Date of last dental cleaning	
How was your child referred to our office?		Reason for seeking orthodontic treatment?		
Has your child ever seen or been treated by another orthodontist?		YES <input type="checkbox"/> NO <input type="checkbox"/>		

## PATIENT MEDICAL HISTORY

How is your child's general health?	YES	NO		YES	NO	Has your child ever had any of the following? (please check yes or no)	YES	NO
Heart abnormality	<input type="checkbox"/>	<input type="checkbox"/>	Any operations?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Does patient take medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Visual impairment	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sore throats	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to latex?	<input type="checkbox"/>	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/Clotting problems	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils/Adenoids removed	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems/Asthma	<input type="checkbox"/>	<input type="checkbox"/>
HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	If female: pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above questions, please explain:

Any other medical condition we should know about?

→ Please turn form over and complete other side

## DENTAL HISTORY

*(Please check yes or no)*

- Has your child ever had a difficult problem associated with previous dental work?
- Does your child ever grind or clench his/her teeth?
- Is your child's water source fluoridated?
- Any injuries to teeth, face or head?
- Does your child have TMJ problems, clicking or painful jaw?
- Does your child have a history of thumb/finger sucking habits, tongue habits?

YES NO

If you answered YES to any of the questions, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current \_\_\_\_\_ Past \_\_\_\_\_ Until age \_\_\_\_\_

Who brushes your child's teeth? \_\_\_\_\_  
When \_\_\_\_\_

## PAYMENT INFORMATION

*(Person responsible for account)*

Name		Social Security #	
Billing Address		Town	Zip Code
Home Phone	Work Phone	Mother's Cell	Father's Cell

Are you or your spouse employed by the U.S. Military or Reserve Corps? YES  NO

### PRIMARY INSURANCE

Name of Insured	
Insured's Social Security #	Insured's birthdate
Employer	Phone #
Employer's Address	Town/Zip code
Name of Insurance Company	Ins. Co. Phone #
Insurance Co. Address	Town/Zip code
Group or ID #	
Dental Coverage? YES <input type="checkbox"/> NO <input type="checkbox"/> Orthodontic Coverage? YES <input type="checkbox"/> NO <input type="checkbox"/>	

### SECONDARY INSURANCE

Name of Insured	
Insured's Social Security #	Insured's birthdate
Employer	Phone #
Employer's Address	Town/Zip code
Name of Insurance Company	Ins. Co. Phone #
Insurance Co. Address	Town/Zip code
Group or ID #	
Dental Coverage? YES <input type="checkbox"/> NO <input type="checkbox"/> Orthodontic Coverage? YES <input type="checkbox"/> NO <input type="checkbox"/>	

*I have read all the information on both sides of this sheet and have completed the above answers. I certify that this information is true and correct and I will notify you of any changes. I authorize the dental staff to perform the necessary dental services I may need. I understand and agree that I am financially responsible for the balance of my account and for any professional services rendered regardless of my insurance. I understand there is no charge for my initial evaluation; however, any orthodontic diagnostic records taken will be charged to my account.*

Signature \_\_\_\_\_

Date \_\_\_\_\_