Associated Orthodontists of Indiana, Inc. – Child Registration

Patient Name_____Male/female birthdate _____/_____/_____Age_____

Preferred Name _____ School _____

Lives with [Mother][Father][other]_____ sibling names & ages_____

Father's Name _____ Mother's Name_____

Address _____ Address _____
Street Apt# Street Apt#

_____ _____
City State Zip City State Zip

Home# _____Cell# _____ Home# _____Cell#_____

Email (optional)_____ Email (optional)_____

Work# _____Employer_____ Work# _____Employer_____

Occupation _____ Occupation_____

Primary Insurance Co _____ Secondary Insurance Co _____

Person responsible for Account _____ Who referred you to this office? _____

MEDICAL HISTORY

Family Dentist_____location _____ Phone#_____

Family physician_____ location _____ Phone#_____

	YES	NO
Are there any general health problems?	☐	☐
Please specify _____		
Any previous hospitalizations or surgeries?	☐	☐
Please specify _____		
Are medications being taken at this time?	☐	☐
Please list _____		
Does the patient have an allergy to any drug?	☐	☐
Please list _____		

Has the patient had any of the following afflictions?		
HIV Symptoms	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Epilepsy	☐	☐
Respiratory Disease	☐	☐
Prolonged Bleeding	☐	☐
Hepatitis	☐	☐
Ear Problems	☐	☐
Nervous or Mental Disorder	☐	☐
Kidney or Liver Disease	☐	☐

Consent It is necessary for parent/guardian to sign permission before any necessary dental service is started for a minor. I grant Associated Orthodontists of Indiana, Inc. permission to provide my child's dental exam and treatment. I will be responsible for the cost of dental care, including attorney fees and court costs that may be necessary to collect any outstanding balance on this account. I, by virtue of my signature of this document, agree to bind myself, the patient and my spouse (mother/father) and we jointly and severally agree to be responsible for treatment for the patient named above and understand the billing will be made jointly and the responsibility of the account is a joint and severally. In filing bankruptcy proceedings, either voluntary or involuntary, Associated Orthodontists of Indiana, Inc., reserves the right to terminate all future treatment and services. I also authorize Associated Orthodontists of Indiana, Inc., to release any information relating to insurance claims and hereby authorize payments to be made directly to Associated Orthodontists of Indiana, Inc.

_____ _____

Parent/Guardian Signature Date