Associated Orthodontists of Indiana, Inc. – Child Registration

Patient Name _____ Male ☐/Female ☐ Date Of Birth ___/___/___ 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 _____ Email _____

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?	Y	N
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