



Darcie R. Bradley, DMD, MS

Specialist in Orthodontics for
Children and Adults

Child Patient Information

Please write in print.

With whom may we thank for referring you to our office? _____

Have we treated any family or friends? _____

Patient Information

Name: _____ Birthdate: _____ Age: _____

Home phone: _____ Cell: _____ Work: _____

Address: _____

How long have you lived at this address? _____

School: _____ Grade: _____

Medical History

Primary care physician: _____ Date of last visit: _____

Please list *all* currently taken medication: _____

Known allergies: _____

Current medical treatment or past hospitalizations: _____

Females only. When was her first menstrual cycle? _____

Is the patient pregnant? Yes No

Taking birth control? Yes No

Does patient have a history with *any* of the following?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Hearing disorder | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Arthritis or rheumatism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sleeping disturbances |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> HIV | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Other _____ | | | |

If you checked *any* of the above, please explain. _____

Does the patient have other medical condition(s) we should be aware of? _____

Dental History

Patient's dentist: _____ How long? _____ How often? _____

Does patient have a history with *any* of the following?

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Previous orthodontic treatment | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Speech impediment | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Mouth/facial injuries | <input type="checkbox"/> Periodontal care | <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Chin scar |
| <input type="checkbox"/> Thumb/finger sucking | <input type="checkbox"/> Mouth breather | <input type="checkbox"/> Snoring while asleep | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Clicking/popping in jaw | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Pain around the ear/earaches | <input type="checkbox"/> Headaches |

If you checked *any* of the above, please explain. _____

Orthodontic Interest

What orthodontic or dental concerns brought you to our office? _____

Is the patient aware of the orthodontic/dental concern? Yes No

Patient's interest in orthodontic care: Wants treatment Treatment if necessary Unwilling, but agrees Minimal

Orthodontic consult prompted by: Patient Dentist Parent/Guardian Physician Friend Other: _____

Orthodontic Interest, Cont.

What are some of your final treatment goals?

- Beautiful smile
- Evenly aligned teeth
- Healthy Bite
- Long term stability
- Ease of treatment
- Improve facial proportions
- Correct overbite
- Eliminate crowding
- Close spaces
- Improve facial appearance
- Eliminate pain
- Short treatment timeline
- Other: _____

Is there anything in particular that you would like to change about your smile? _____

Billing Party Information *(Complete as the legal guardian present to accept responsibility of assigned orthodontic fees.)*

Name: _____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Employer: _____ How long? _____

Employer's address: _____ City: _____ State: _____ ZIP: _____

Occupation: _____ Work #: _____ Cell #: _____

Dental Insurance: _____ *(Complete as the insurance policy holder/primary subscriber.)*

Address listed on card: _____ Subscriber name: _____

_____ * Subscriber SS#: _____

Phone number listed on card: _____ * Subscriber DOB: _____

ID: _____ Employer: _____

Group: _____

Communication Preferences

Phone: _____

Email: _____

Secondary email for billing and statement: _____

Emergency contact name: _____ Relationship: _____ Phone: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The questions on both pages have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the orthodontist to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of such dental care to third party payer and/or health practitioners. I understand this may include the release of information concerning HIV testing, diagnosis, or treatment of AIDS, AIDS related conditions, drug or alcohol abuse or related conditions, any psychiatric and/or psychological conditions. I agree to be responsible for payment of all services rendered on my behalf. I understand that any balance carried on the house accounts after thirty (30) days from the date of service, will be charged interest on the unpaid balance at 1 1/2 percent per month, compounded monthly, at an annual percentage rate of 18%. I understand that I am subject to credit checks before and/or during the course of treatment (includes new and current patients).

Parent/ Guardian Initials

Acknowledgement: Receipt of Privacy Practices Notice

I have received a copy of this office's Notice of Privacy Practices.

Media Consent

I grant Dr. Darcie R. Bradley, DMD, MS, Orthodontics permission to use my (or my children's) photos or videos taken before, during, or after treatment. These may be shared on social media, the office website, or other promotional materials to showcase patient smiles. Photos and videos will only be used by Dr. Bradley's office.

Parent/guardian signature: _____ Date: _____

Printed name of parent/guardian: _____

My relationship to the patient: _____