Chad Bulleigh, D.D.S.

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(913) 381-1122

Today's Date:______________________________

Child's Name:____ I prefer to be called:________________
First MI Last

Mailing Address:____
City State Zip

Phone:(______)______________ Birthday:________________ Age: ______ Male________ Female________

Hobbies/Sports:____

List musical instruments played:____

Father's Information ____Step Father ____Guardian

Name:______________________________________
First MI Last

Mailing Address:________________________

City:______________ State:________ Zip:________

Home Phone:(______)________________

Work Phone:(______)________________ Ext:________

Date of Birth:________________________

Marital Status:________ S.S. #:________________

Cell Phone:________________________

Employer/Insurance Information

Employer Name:________________________

Employer Mailing Address:________________________

____
City State Zip

Orthodontic Coverage? Yes____ No____

Insurance Company Name:________________________

Insurance Mailing Address:________________________

____
City State Zip

Insurance Phone:(______)______________ Ext:________

Group #:______________ Local or Union #:______________

Mother's Information ____Step Mother ____Guardian

Name:______________________________________
First MI Last

Mailing Address:________________________

City:______________ State:________ Zip:________

Home Phone:(______)________________

Work Phone:(______)________________ Ext:________

Date of Birth:________________________

Marital Status:________ S.S. #:________________

Cell Phone:________________________

Employer/Insurance Information

Employer Name:________________________

Employer Mailing Address:________________________

____
City State Zip

Orthodontic Coverage? Yes____ No____

Insurance Company Name:________________________

Insurance Mailing Address:________________________

____
City State Zip

Insurance Phone:(______)______________ Ext:________

Group #:______________ Local or Union #:______________

Who is the responsible party?________________________

Who will make appointments?________________________

Dentist's name:________________________

Date of last dental visit:________________________

Physician's name:________________________

Whom may we thank for referring you?______________

School name:________________ Grade:____

List other family members seen by us:______________

____

Physician's phone number:(______)______________

E-mail:______________________________

MEDICAL HISTORY

Has your child ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	Allergies to any Drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Murmur
Y	N	Any Operations	Y	N	Hemophilia
Y	N	Asthma	Y	N	Hepatitis
Y	N	Cancer	Y	N	HIV+ / AIDS
Y	N	Congenital Heart Defect	Y	N	Rheumatic / Scarlet Fever
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

____

____

Is your child currently under the care of a physician?______

Has puberty begun?______________________

Has menstruation begun (Girls)?______________________

Please describe your child's current physical health:

_______ Good _______ Fair _______ Poor

Please list all drugs that your child is currently taking:__________

____

Please list all drugs that your child is allergic to:__________

____

In the event of an emergency, is there a neighbor or relative not living with you that we should contact?

Name:______________________

Relation:______________________

Work Phone Number:(   )______________

Home Phone Number:(   )______________

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

____

____

____

Has your child ever been evaluated or had orthodontic treatment before?______________

Have there been any injuries to the face, mouth, teeth or chin?______________

Have adenoids or tonsils been removed?__________

Has your child been informed of any missing or extra permanent teeth?__________

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)?__________

Does your child brush his / her teeth daily?______

Does your child floss his / her teeth daily?______

Does / did your child have any of the following habits?

Y	N	Clenching / Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb/Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in 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 any necessary dental services my child may need.

____

Signature of parent or guardian   Date

Thank you for filling out this form completely.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

____

Signature of parent or guardian   Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.