Robert S. Muirhead, DDS, MS

Specializing in Orthodontics for Children & Adults

6086 FM 2920 Rd. Spring, TX 77379/281-376-5858

Patient Name_____M____ F____Birth Date_____

Home Address_____City_____Zip_____

Primary Phone_____Home____Cell____ ok to leave message Y____ N____

Secondary Phone_____Home____Cell___ Other___ of to leave message Y____ N____

Email _____School_____

Siblings_____

Parent's Marital Status Single _____Married_____Divorced_____Widowed_____Significant Other_____

Mother_____Step-Mother____Guardian____Other_____Name_____

Social Security #_____Birth Date_____

Address(if different than child's)_____

City_____State_____Zip_____

Phone#_____home___ cell_____Secondary phone_____home___cell____

Employer's Name_____

Father_____Step-Father_____Guardian_____Other_____Name_____

Social Security#_____Birth Date_____

Address(if different than child's)_____

City_____State_____Zip_____

Phone#_____home___cell____Secondary phone_____home____cell_____

Employer's Name_____

General Dentist_____Last Visit_____

How did you hear about our office?Ad___Internet___Family/Friend___Physician___Other_____

Name of person referring you._____

Primary Insurance_____Phone #_____Group#_____

Policy Holder's Name_____Relation_____

Social Security#_____Birth Date_____Employer_____

Secondary Insurance_____Phone#_____Group#_____

Policy Holder's Name_____Relation_____

Social Security#_____Birth Date_____Employer_____

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

Has your child visited an orthodontist before? Y___ N___When?_____Reason?_____

Have we treated any other famly members/ Y___N___ Name_____

Have your child's tonsils/adenoids been removed? Y___N___ Does your child have any missing or extra teeth? Y___ N___

Has your child experienced any jaw joint pain?discomfort(TMJ/TMD) ? Y____ N____

Has your child ever had an injury(select all that apply) Teeth Y___ N___ Mouth Y___ N___ Chin Y___ N___

Does your child have speech problems? Y___ N___ If so. Explain_____

Does your child currently or has your child ever had any of the following (check all that apply)

Clenching/Grinding_____ Nail Biting_____ Lip Sucking/Biting_____

Thumb/Finger Sucking_____ Mouth Breathing_____ Chewing/Eating Problems_____

Is your child currently being treated by a physician? Y____ N____Physician_____Phone_____

Reason_____

Does your child have any allergies/sensitivities to medications or latex? Y____ N____ If yes, please list allergies_____

Please list any prescription/over the counter medications your child is currently taking._____

Has puberty and/or menstruation begun? Y_____ N_____

- 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 the office of any changes in my child's medical status.
- I hereby authorize the release of any information pertaining to my child's medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.
- I understand that where appropriate, credit bureau reports may be obtained
- Parent Signature/and or Responsible Party_____Date_____

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Specializing in Orthodontics for Children & Adults

6086 FM 2920 Rd. Spring, TX 77379/281-376-5858

Patient Name_____Male___ Female___

Social Security #_____Birth Date_____

Home Address_____

City_____State_____Zip_____

Primary Phone#_____Home____ Cell____ ok to leave message Y___ N___

Secondary Phone # _____Home____Cell____ Other___ ok to leave message Y___ N

Email Address_____

Employer's Name_____

Marital Status Single___ Married___ Divorced___ Widowed Significant Other___

Spouse/Partner's Name_____

Address if different_____City_____State_____Zip_____

Phone#_____Relation _____

Person(s) OK to release appointment/treatment/financial related information to concerning you.

_____Relation _____

Primary Insurance

Company_____Phone#_____

Policy Holder's Name_____Relation_____Birth Date_____

Social Security/ID#_____ Employer_____Group#_____

Secondary Insurance Company_____Phone #_____

Policy Holder's Name_____Relation_____Birth Date_____

Social Security#/ID#_____Employer_____Group#_____

General Dentist_____Last Visit_____

How did you hear about our office?Ad___ Internet___ Family/Friend___ Physician___ Other___

Name of person referring you (if applicable)_____

What are your main concerns you would like orthodontics to accomplish?

Have you visited an orthodontist before? Y___ N___

When?_____Reason_____

Have your tonsils been removed?Y___ N___Have you ever had an injury to(select all that applies) Teeth___Mouth___Chin___

Have you ever experienced jaw joint pain/discomfort(TMJ/TMD) ? Y___ N__Do you have any missing/extra teeth? Y___N___

Do you have speech problems? Y___ N___ If so, explain_____

Do your gums bleed? Y___ N___ Do you smoke? Y___ N___ Do you like your smile? Y___ N___

Do you currently or have you ever had any of the following habits(check all that apply) ?

Clenching/Grinding _____ Nail Biting_____ Lip Sucking/Biting _____
Thumb/Finger Sucking ____ Mouth Breathing ____ Chewing/Eating Problems ___

Are you currently being treated by a physician? Y___ N__ Physician_____Phone_____

Reason_____

Do you have any allergies/sensitivities to medications or latex? Y___ N___ If yes, please list allergies_____

Please list any prescriptions/medications you are taking at this time._____

Are you pregnant or nursing? Y___ N___

*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 of confidence and it is my responsibility to inform the office of any changes in my medical status.

*I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

* I understand that where appropriate, credit bureau reports may be obtained.

Patient Signature and/or Responsible Party(i.e. POA or Guarantor)_____

Date_____