RYCKMAN ORTHODONTICS

MICHAEL RYCKMAN,DMD,MSD

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

ABOUT YOUR CHILD

Today's Date_____/_____/_____ ☐ Male ☐ Female

Child's Name:_____
Last First MI

Preferred Name:_____

Date of Birth:_____ Age:_____

School:_____Grade:_____

Hobbies/Sports:_____

Child's Home #:_____

Child's Home Address:_____

_____
City State Zip

WHO IS ACCOMPANYING THE CHILD TODAY?

Name:_____Relation:_____

Do you have legal custody of child? ☐ Yes ☐ No

Parent's marital status ☐ Single ☐ Married
☐ Widowed ☐ Divorced ☐ Separated

Who may we thank for referring you?_____

Family members treated here:_____

DENTAL HISTORY

Child's Dentist:_____

Office Name:_____

Office Address:_____

_____
City State Zip

Office Phone #:_____

Last Seen:_____Reason:_____

Next Appointment:_____

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

☐ Yes	☐ No	Lip Sucking/Biting
☐ Yes	☐ No	Nursing Bottle Habits
☐ Yes	☐ No	Thumb/Finger Sucking
☐ Yes	☐ No	Consume Sugary Drinks
☐ Yes	☐ No	Clenching/Grinding Teeth
☐ Yes	☐ No	Tongue Thrust
☐ Yes	☐ No	Mouth Breather
☐ Yes	☐ No	Speech Problems
☐ Yes	☐ No	Nail Biting

WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH?

What is your chief complaint?

_____

_____

Has this child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been injuries to the face, mouth, teeth, or chin? ☐ Yes ☐ No

List any musical instrument(s) played_____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Currently under the care of a physician? ☐ Yes ☐ No

Child's Physician:_____

Physician's Phone #:_____

Date of Last Visit:_____

Has puberty begun? ☐ Yes ☐ No

Please describe the child's current physical health:
☐ Good ☐ Fair ☐ Poor

Please list all medications that the child is currently taking:

_____

_____

Please list all medications/items that the child allergic to:

_____

_____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

☐ Yes	☐ No	Artificial Bones/Joints
☐ Yes	☐ No	Artificial Valves
☐ Yes	☐ No	Asthma
☐ Yes	☐ No	Cancer
☐ Yes	☐ No	Congenital Heart Defect
☐ Yes	☐ No	Convulsions/Epilepsy
☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Handicaps/Disabilities
☐ Yes	☐ No	Hearing Impairment
☐ Yes	☐ No	Heart Murmur
☐ Yes	☐ No	Hemophilia
☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	HIV+/AIDS
☐ Yes	☐ No	Kidney/Liver Problems
☐ Yes	☐ No	Rheumatic/Scarlet Fever
☐ Yes	☐ No	Tuberculosis (TB)

Please elaborate as necessary for any 'Yes' answers

_____

_____

1007 Shroyer Road, Dayton, OH 45419 - Phone (937) 294-1001- Fax (937) 294-0798
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www.Braces4Dayton.com

Account and Insurance Information

RYCKMAN ORTHODONTICS

MICHAEL RYCKMAN,DMD,MSD

Patient's Name: _____

Today's Date: _____

PARENT'S INFORMATION

☐ Mother ☐ Father ☐ Step Mother ☐ Step Father ☐ Guardian

Name:_____
Last First MI
Date of Birth:_____
Email:_____
Home #:_____Cell #:_____
Employer:_____
Work #:_____ Ext._____

☐ Mother ☐ Father ☐ Step Mother ☐ Step Father ☐ Guardian

Name:_____
Last First MI
Date of Birth:_____
Email:_____
Home #:_____Cell #:_____
Employer:_____
Work #:_____ Ext._____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____
Relationship to Child:_____
Address:_____
_____
City State Zip
Phone #:_____
Email:_____

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT 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 AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES MY CHILD MAY NEED.

SIGNATURE OF PARENT OR GUARDIAN DATE

If you have dental insurance with orthodontic coverage, please complete the following information.

PRIMARY DENTAL INSURANCE

Policy Holder's Name:_____

Relationship to Patient:_____
Address:_____
_____
City State Zip
Phone #:_____DOB:_____
SSN or Member ID:_____
Employer:_____
Employer's Address:_____
_____
City State Zip
Insurance Company Name:_____
Insurance Company Address:_____
_____
City State Zip
Group #:_____
Phone #:_____

SECONDARY DENTAL INSURANCE

Policy Holder's Name:_____

Relationship to Patient:_____
Address:_____
_____
City State Zip
Phone #:_____DOB:_____
SSN or Member ID:_____
Employer:_____
Employer's Address:_____
_____
City State Zip
Insurance Company Name:_____
Insurance Company Address:_____
_____
City State Zip
Group #:_____
Phone #:_____

I HAVE REVIEWED THE FOLLOWING PLAN(S). I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT.

SIGNATURE OF PARENT OR GUARDIAN DATE