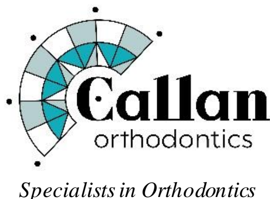


*Specialists in Orthodontics*

Christopher Callan, DMD, MS
**NJ SP#6776**

## PATIENT INFORMATION

Name: ________________________________________ Nickname: ___________________ Today's Date: ________________________

Birth date: ___________ Age: ______ Gender: ☐ M ☐ F School: _____________________________________________ Grade: _______

Address: ____________________________________________ City: ______________________ State: ________ Zip Code: ___________

Primary number for appointment confirmations: ______________________________ Email: ________________________________ _____

Who referred you to our office? _________________________ Who is responsible for making appointments: __________________________

## RESPONSIBLE PARTY INFORMATION

### Guardian (1)

Name: ______________________________ Gender: ☐ M ☐ F

Relationship: ________________________________________

Social Security #: ______________ Birthdate: ______________

Primary Phone #: ______________________ ☐ H ☐ C ☐ W

Secondary Phone #: ____________________ ☐ H ☐ C ☐ W

Email: _______________________ DL#: _________________

Employer: _______________________________________

Employer Phone#: ________________ Occupation: __________

☐ *Check box if address is the same as patient's listed above.*

Address: _________________________________________

City: _____________________ State: _____ Zip Code: ________

### Guardian (2)

Name: ______________________________ Gender: ☐ M ☐ F

Relationship: ________________________________________

Social Security #: ______________ Birthdate: ______________

Primary Phone #: ______________________ ☐ H ☐ C ☐ W

Secondary Phone #: ____________________ ☐ H ☐ C ☐ W

Email: _______________________ DL#: _________________

Employer: _______________________________________

Employer Phone#: ______________ Occupation: ___________

☐ *Check box if address is the same as patient's listed above.*

Address: _________________________________________

City: _____________________ State: _____ Zip Code: _______

## DENTAL INSURANCE INFORMATION

### Primary Coverage

Policyholder's Name: __________________________________

Policyholder's Birthdate: ____________ Relationship: __________

Social Security #: ________________ Member Id #: __________

Insurance Company: __________________ Group #: ________

Claims Address: _______________________________________

Employer: ___________________________________________

Employer's Phone #: __________________________________

### Secondary Coverage

Policyholder's Name: __________________________________

Policyholder's Birthdate: ____________ Relationship: __________

Social Security #: ________________ Member Id #: __________

Insurance Company: __________________ Group #: ________

Claims Address: _______________________________________

Employer: ___________________________________________

Employer's Phone #: __________________________________

## DENTAL HISTORY – Check All That Apply

Dentist Name________________________________ Ever had an orthodontic consult/treatment: ☐Y ☐N

Main orthodontic concern: ______________________________________________________________

| | Yes | No |
|---|---|---|
| Brush teeth daily? | | |
| Floss teeth daily? | | |
| Numerous fillings? | | |
| Mouth breathing? | | |
| Snores during sleep? | | |
| Speech problems/therapy? | | |
| Apprehensive about dental care? | | |
| Frequently chews gum? | | |
| Thumb or finger habit as a child | | |
| Jaw fractures, cysts, mouth infections | | |
| Bleeding gums | | |
| Other periodontal (gum) problems | | |
| Frequent canker sores or cold sores | | |
| Have wisdom teeth been removed | | |

| | Yes | No |
|---|---|---|
| Is all dental work completed at this time? | | |
| Grind or clench teeth? | | |
| Oral habits (thumb/finger habit, lip/nail biting)? | | |
| Injury to face, jaw, teeth, or mouth? | | |
| Discomfort from teeth or gums? | | |
| Frequent Sore Throats? | | |
| Frequent headaches? | | |
| Issues with food stuck between teeth? | | |
| Chipped or injured permanent teeth | | |
| Teeth sensitive to hot or cold | | |
| Teeth that irritate tongue, cheek, lip? | | |
| Bad taste/mouth odor | | |
| Previous periodontal (gum) treatment | | |
| Abnormal swallowing (tongue thrust) | | |

## MEDICAL HISTORY – Check All That Apply

Child's Pediatrician: ____________________________________________ Phone #: _________________ Date of Last Exam: _________

Is your child vaccinated? ☐Y ☐ N Immunization current? ☐ Y ☐ N Current Medications: __________________________________

History of hospitalization or surgery: ______________________________________________________________ ______________________

Allergies/Sensitivities: ____________________________________________ Phobias: ____________________________________________

**DIAGNOSIS/TREATMENT** (check all that apply)

☐ ADHD/ADD ☐ Cardiac Disease/Heart ☐ Hepatitis/Liver Disease ☐ Immune Disorder ☐ Anemia/Blood Disorder

☐ Asthma ☐ Bladder/Kidney ☐ Arthritis/Joint Disorder ☐ Bone Disorder ☐ Abnormal Bleeding/Hemophilia

☐ Autism Spectrum ☐ Earaches/Infections ☐ Down's Syndrome ☐ Epilepsy/Seizure ☐ Cognitive/Social Delay

☐ Diabetes ☐ Speech Disorder/Delay ☐ Rheumatic Fever ☐ Cerebral Palsy ☐ Premature/Low Birth Weight

☐ Tuberculosis ☐ Delayed Development ☐ Cystic Fibrosis ☐ TMJ Problems ☐ Chemo/Radiation Therapy

☐ Brain Injury ☐ Muscular Disorder ☐ Cancer/ Malignancy ☐ Sensory Issues ☐ Emotional/Behavioral Issues

☐ Acid Reflux ☐ Depression/Anxiety ☐ Tobacco Use ☐ Pregnancy ☐ Hearing/Visual Impaired

☐ Special Needs ☐ Thyroid Disorder ☐ Gag Reflex ☐ HIV/ AIDS ☐ Heart Murmur/Defect/Surgery

☐ Cleft Lip/ Palate ☐ Stomach/GI Disorder ☐ Eating Disorder ☐ Hearing/Vision Problems

Other: ____________________________________ If yes to any of the above, please detail. ____________________________________

______________________________________________________________________________________________________________

**Authorization & Release**

To the best of my knowledge, I have accurately answered the questions on this form. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in the patient's medical status. I also authorize the dental staff to perform all necessary dental services the patient may need, including guidelines outlined by the AAO for routine radiographs. I understand that Callan Orthodontics may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Callan Orthodontics all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

_____________________________________________ _______________________ _______________________

Signature of Responsible Party Relationship to child Date

_____________________________________________________________ _______________________

Signature of Dentist Date