Rebecca Falsafi, D.D.S., M.S.
Orthodontics and Orthopedics for Children and Adults

6161 Transit Road
Suite 10
East Amherst, New York 14051
(716) 631-2166
www.falsafiortho.com

WELCOME TO THE ORTHODONTIST!

Please fill out this form completely, the better we communicate, the better we can care for your child. It is important for us to make every child's visit fun and informative. Our mission is to create beautiful smiles that last forever.

ABOUT YOUR CHILD:

Today's Date:_____ Child's Birth date:____/____/____ Age:_____Male Female
Name:_____ Nickname:_____
LAST FIRST M.I.
Home Address:_____
CITY STATE ZIP
Home #:(____)_____Cell #:(____)_____Work #:(____)_____
Email Address:_____Child's School:_____Grade:_____

PARENT'S INFORMATION:

Mother's Information: Mother Stepmother Legal Guardian
Name: _____ Birth date: ____/____/____ SS #____-____-____
Home#: (____)_____Work #: (____)_____Ext:_____ DL #_____
Employer:_____ Job Title:_____ How long at job_____
Marital Status: Single Married Partnered Separated Divorced Widowed

Father's Information: Father Stepfather Legal Guardian
Name:_____ Birth date:____/____/____ SS #____-____-____
Home#: (____)_____Work #: (____)_____Ext:_____ DL #_____
Employer:_____ Job Title:_____ How long at job_____
Marital Status: Single Married Partnered Separated Divorced Widowed

Who is accompanying your child to the consultation? Mother Father Both Other _____
If other, do you have legal custody of child? Yes NO
Who is your child's General Dentist:_____Last Visit Date:_____
How did you hear about out office? Dentist Patient Family Website Phone Book
Please list brothers and sisters names and ages:_____

PERSON RESPONSIBLE FOR ACCOUNT:

Name:_____ Relationship: Mother Father Other _____
PLEASE FILL OUT ADDITIONAL INSURANCE INFORMATION FORM IF YOU HAVE ANY DENTAL INSURANCE

PERSON RESPONSIBLE FOR MAKING APPOINTMENTS

Name:_____ Relationship: Mother Father Other _____
Any additional phone numbers to reach you at (other than listed above): (____)_____

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

_____ **Relationship:_____ Date:____/____/____**
SIGNATURE OF PARENT OR GUARDIAN

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PLEASE FILL OUT THE FOLLOWING ABOUT YOUR CHILD'S HEALTH HISTORY:

Child's Name: _____
Child's Physician:_____**Office Number:(___)**_____
What are your main concerns you would like orthodontics to accomplish?_____

_____

Has your child ever taken Phen-Fen?	**Yes ☐ No ☐**	
If so when was it taken? _____		
Has your child ever been evaluated or had previous orthodontic treatment?	**Yes ☐ No ☐**	
Have there been any injuries to the face, mouth, teeth or chin?	**Yes ☐ No ☐**	
If so please describe_____		
Does your child play any musical instruments?	**Yes ☐ No ☐**	
Have tonsils or adenoids been removed?	**Yes ☐ No ☐**	
Does your child have any missing or extra permanent teeth?	**Yes ☐ No ☐**	
Has your child's wisdom teeth been removed?	**Yes ☐ No ☐**	
Has your child experienced any pain in jaw, joint tenderness or clicking/popping?	**Yes ☐ No ☐**	
Does your child brush their teeth daily?	**Yes ☐ No ☐**	
Do they floss daily?	**Yes ☐ No ☐**	
Has Puberty begun?	**Yes ☐ No ☐**	
Has menstruation begun (females)?	**Yes ☐ No ☐**	
Does your child have overall good physical health?	**Yes ☐ No ☐**	
Does your child have a latex allergy?	**Yes ☐ No ☐**	
Does your child have any allergies to metal?	**Yes ☐ No ☐**	
Does your child have sensitivity to cheap jewelry?	**Yes ☐ No ☐**	
Does your child have any allergies to plastics?	**Yes ☐ No ☐**	
Does your child have allergies to any Food or Medication?	**Yes ☐ No ☐**	**If Yes, please list:**

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING?

Tuberculosis	**Yes ☐ No ☐**	**Any Abnormal Bleeding**	**Yes ☐ No ☐**
Rheumatic/Scarlet Fever	**Yes ☐ No ☐**	**Any Hospital Stays**	**Yes ☐ No ☐**
Lupus	**Yes ☐ No ☐**	**Any Operations**	**Yes ☐ No ☐**
Kidney/Liver Problems	**Yes ☐ No ☐**	**Artificial Bones/Joints/Valves**	**Yes ☐ No ☐**
HIV+/ Aids	**Yes ☐ No ☐**	**Asthma**	**Yes ☐ No ☐**
Hepatitis	**Yes ☐ No ☐**	**Cancer**	**Yes ☐ No ☐**
Hemophilia	**Yes ☐ No ☐**	**Congenital Heart Defect**	**Yes ☐ No ☐**
Heart Murmur	**Yes ☐ No ☐**	**Convulsions/Epilepsy**	**Yes ☐ No ☐**
Hearing Impairment	**Yes ☐ No ☐**	**Diabetes**	**Yes ☐ No ☐**
Handicaps/Disabilities	**Yes ☐ No ☐**		

HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING?

Clenching of teeth	**Yes ☐ No ☐**	**Prolonged Nursing/ Pacifier**	**Yes ☐ No ☐**
Lip/Cheek Biting	**Yes ☐ No ☐**	**Speech Problems**	**Yes ☐ No ☐**
Mouth Breathing	**Yes ☐ No ☐**	**Thumb/ Finger Sucking**	**Yes ☐ No ☐**
Nail Biting	**Yes ☐ No ☐**	**Tongue Thrust**	**Yes ☐ No ☐**

I understand that the Information I have given is correct to the best of my knowledge, that it will be held in confidence in compliance with the HIPPA regulations and that it is my responsibility to inform the office of any changes in my child's personal or medical status.

_____ **Relationship:** _____ **Date:**___/___/___
SIGNATURE OF PARENT OR GUARDIAN

_____

OFFICE USE ONLY:
Reviewed Medical History Yes ☐ No ☐ **WNL Yes ☐ No ☐** **Initials**_____ **Date**__/___/___