304-744-6311 (WV)
Welcome to our office!

PANUCCI
Donna L. Panucci, DDS

JACKFERT
Lindsay M. Jackfert, DDS, MS

740-446-6202 (OH)
Come Smile with us!

Date: ______ Patient prefers to be called: ______

Child's Name: ______ Male/ Female
Last First Middle

Birthdate: ______ Age: ______ Social Security #: ______

Child's Home Address: ______
Street City State Zip

School: ______ Grade: ______ Child's Phone #: ______

Hobbies/Sports:

Who is accompanying the patient today? ______
Name Relationship to child

Do you have legal custody of this child? Yes No Custodial Parent: ______

Whom may we thank for referring you to our office? ______

List Siblings	Date of Birth	Sex:	Ortho Treatment	Orthodontist
		M or F	Y or N	
		M or F	Y or N	
		M or F	Y or N	
		M or F	Y or N	

Have parents had orthodontic treatment? Mother Father Orthodontist: ______

Parents' Marital Status (please circle one): Single Married Divorced Partnered Separated Widowed

Parent's Information

Name: ______ Birthdate: ______

Address: ______

Cell #: ______ Home # (if not cell): ______

SSN: ______ Email: ______

Employer: ______ Occupation: ______ Work #: ______

Parent's Information

Name: ______ Birthdate: ______

Address: ______

Cell #: ______ Home # (if not cell): ______

SSN: ______ Email: ______

Employer: ______ Occupation: ______ Work #: ______

Stepparent/Guardian Information

Name: ______ Birthdate: ______

Cell #: ______ Home # (if not cell): ______

SSN: ______ Email: ______

Employer: ______ Occupation: ______ Work #: ______

Stepparent/Guardian Information

Name: ______ Birthdate: ______

Cell #: ______ Home # (if not cell): ______

SSN: ______ Email: ______

Employer: Occupation: Work #:

CONTINUED ON BACK

What main concerns do you want to address with orthodontic treatment? ______________________

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

Describe if yes: ______________________ Orthodontist: ______________

Name of patient's general dentist: ______________________ Date of last dental visit: __________

Dentist's address : ______________________ Phone #: ______________

Does your child require antibiotic premedication before dental procedures? Yes No

Has your child ever experienced any of the following?

Y	N	Oral Surgery	Y	N	Nail Biting	Y	N	Thumb/Finger Sucking Habit
Y	N	Sensitive Teeth	Y	N	Speech Problems			Until what age? ______
Y	N	Gum Treatment	Y	N	Mouth Breathing	Y	N	Pacifier Habit
Y	N	Removal of Teeth	Y	N	Tongue Thrust			Until what age? ______
Y	N	Sore, Bleeding Gums	Y	N	Lip Sucking/Biting	Y	N	Have tonsils and/or adenoids
Y	N	Root Canal Therapy	Y	N	Clenching/Grinding			been removed?

If YES to any of the above, please explain: ______________________

Has your child had any injuries to the face, mouth, teeth or chin? Yes No

Describe if yes: ______________________

Have you been informed that your child has missing, impacted or extra permanent teeth? Yes No

Describe if yes: ______________________

Has your child had any pain/tenderness/noises in his/her jaw joint (TMJ/TMD), ears, temples or cheeks? Yes No

Describe if yes:

Child's Physician: ______________________ Phone #: ______________

Is your child currently under the care of a physician? Yes No Date of last visit: ______________

Describe if yes: ______________________

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

Y	N	Abnormal Bleeding	Y	N	Bone Disorder	Y	N	Hepatitis
Y	N	ADD/ADHD	Y	N	Cancer	Y	N	Herpes
Y	N	Anemia	Y	N	Diabetes	Y	N	HIV/AIDS
Y	N	Arthritis	Y	N	Endocrine Problems	Y	N	Kidney Disorder
Y	N	Artificial Joints/Valves	Y	N	Epilepsy/Convulsions	Y	N	Liver Disorder
Y	N	Asthma	Y	N	Frequent Headaches	Y	N	Mitral Valve Prolapse
Y	N	Behavioral/Emotional Problems	Y	N	Hearing Impairment	Y	N	Tuberculosis
Y	N	Blood Disease	Y	N	Heart Murmur/Heart Problems			

Any other medical conditions or serious illnesses that we should be aware of? Yes No

Describe if yes: ______________________

Allergies to any medicines or other substances? Yes No

Describe if yes: ______________________

Y N Is your child in good health?

Y N Any changes in general health within the past year?

Y N Has your child ever been hospitalized?

If yes, for what reason? ______________________

Y N Has your child ever had surgery?

If yes, for what reason? ______________________

Y N Sudden increase in your childs height?

Y N If female, has your child started to menstruate?

Y N If female, is your child pregnant?

Please list any current medications your child is taking and the reason for which he/she is taking them:

PANUCCI JACKFERT
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Patient Name: ______________________________

Primary Dental Insurance

Employer/Company Name: ______________________ Employer Phone #: ______________
Insurance Company Name: ______________________________
Insurance Company Phone #: ______________________ Group, Policy, Plan or Local #: ______________
Employee's Name: ______________________ Relationship to patient: ______________
Employee's SSN: ______________________ Employee's Birthday: ______________

Secondary Dental Insurance

Employer/Company Name: ______________________ Employer Phone #: ______________
Insurance Company Name: ______________________________
Insurance Company Phone #: ______________________ Group, Policy, Plan or Local #: ______________
Employee's Name: ______________________ Relationship to patient: ______________
Employee's SSN: ______________________ Employee's Birthday: ______________

I authorize Panucci & Jackfert Orthodontics to bill my insurance for any expenses incurred for orthodontic treatment and for payment to be made directly to Panucci & Jackfert Orthodontics. I also give authorization for the office of Panucci & Jackfert Orthodontics to release any necessary information to my insurance for the processing of any orthodontic claim.

____
Signature of Parent or Guardian Date

Emergency Contact Information

Name of nearest relative that has not been previously listed:

Name: ______________________ Relationship to patient: ______________
Home #: ______________ Cell #: ______________ Email: ______________

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services, including x-rays.

Payment arrangements are made for your convenience and are to be made until the full amount of your contract has been paid, even when treatment is completed prior to balance being paid in full. We do report delinquencies to the credit bureaus.

____
Signature of Parent or Guardian Date

HEALTH HISTORY UPDATES

Date Reviewed: ______________________ Reviewed By: ______________________

Date Reviewed: ______________________ Reviewed By: ______________________