

# Russell E. Little, D.D.S.

ORTHODONTIST

855 West Seventh Street – Suite 2

Reno, Nevada 89503

Telephone (775) 329-0555 • Toll Free (866) 787-8836 • Fax (775) 329-0343

www.biggestlittlesmiles.com

We would like to welcome you and your child to our office. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below:

**Child's Name:** \_\_\_\_\_ Nickname: \_\_\_\_\_

Male  Female  Birthdate: LAST \_\_\_\_ / \_\_\_\_ / \_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ Age: \_\_\_\_\_ Home #: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

School: \_\_\_\_\_ APT/CONDO # \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
Grade: \_\_\_\_\_ Hobbies/Sports: \_\_\_\_\_

Do father, mother and child reside together? Yes  No

If no, with whom does child reside? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

List brothers / sisters with age: \_\_\_\_\_

General Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

Parent's Marital Status: Single  Married  Widowed  Divorced  Separated

**Mother's Information:** Mother  Stepmother  Guardian

Name: \_\_\_\_\_ SS #: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Wk. #: \_\_\_\_\_ ext.: \_\_\_\_\_

How long at current job: \_\_\_\_\_ Job Title: \_\_\_\_\_ Drivers Lic. #: \_\_\_\_\_

**Father's Information:** Father  Stepfather  Guardian

Name: \_\_\_\_\_ SS #: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Wk. #: \_\_\_\_\_ ext.: \_\_\_\_\_

How long at current job: \_\_\_\_\_ Job Title: \_\_\_\_\_ Drivers Lic. #: \_\_\_\_\_

**Person Responsible for Account:** \_\_\_\_\_ SS #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relation: \_\_\_\_\_ Wk. #: \_\_\_\_\_ Hm. #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Employer: \_\_\_\_\_ Drivers Lic. # \_\_\_\_\_

## PRIMARY ORTHODONTIC INSURANCE:

Orthodontic Coverage? Yes  No  Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Policy Owner's SS #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

(Continued on back)

**SECONDARY ORTHODONTIC INSURANCE**

Orthodontic Coverage:  Yes  No Insurance Co. Name: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insurance Co. Phone #: \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_  
Policy Owner's Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Policy Owner's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Owner's SS #: \_\_\_\_\_  
Policy Owner's Employer: \_\_\_\_\_

**What are the main concerns that you would like orthodontics to accomplish?** \_\_\_\_\_

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

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

Have adenoids or tonsils been removed?  Yes  No

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

- |     |                            |     |                           |     |                            |
|-----|----------------------------|-----|---------------------------|-----|----------------------------|
| Y N | Abnormal Bleeding          | Y N | Hearing Impairment        | Y N | Clenching / Grinding Teeth |
| Y N | Allergies to any Drugs     | Y N | Heart Murmur              | Y N | Lip Sucking / Biting       |
| Y N | Allergic to Latex / Metals | Y N | Hepatitis                 | Y N | Mouth Breather             |
| Y N | Asthma                     | Y N | HIV+ / AIDS               | Y N | Nail Biting                |
| Y N | Cancer                     | Y N | Kidney / Liver Problems   | Y N | Speech Problems            |
| Y N | Congenital Heart Defect    | Y N | Rheumatic / Scarlet Fever | Y N | Thumb / Finger Sucking     |
| Y N | Convulsions / Epilepsy     | Y N | Tuberculosis (TB)         | Y N | Tongue Thrust              |
| Y N | Diabetes                   |     |                           |     |                            |

Please discuss any medical problems that your child has had: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_ Is your child currently under the care of a physician?  Yes  No

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

Please list all drugs your child is currently taking: \_\_\_\_\_

Please list all drugs your child is allergic to: \_\_\_\_\_

- This office reserves the right to verify the credit status of parents of patients prior to extending credit for treatment fees.
- 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 it is my responsibility to inform this office of any changes in my child's medical status.

\_\_\_\_\_  
Signature Date