Daniel L. Kaler DDS,PC
Practice Limited to Orthodontics
4224 Sergeant Road
Sioux City, Iowa 51106
712-276-2766
Sioux City LeMars Wayne
Daniel Kaler DDS
Brenda Dick DDS

WELCOME

We would like to welcome you and your child to our office. In an effort to Provide the best service possible, we ask you to fill out this form as completely as possible, Thank You for your cooperation.

CHILD PATIENT INFORMATION

NAME: ______________ Last ______________ First ______ Middle ____ M/F

ADDRESS: ______________ Street ______________ City ______ State ______ Zip

BIRTHDATE: _______/_______/__________ AGE: ____ Primary Contact PHONE # ______________

FAMILY DENTIST: ______________ LAST DENTAL CHECKUP: ______________

Who May We Thank for Referring You to Our Office? ______________

Please Describe Your Childs Orthodontic Problem ______________

PARENT INFORMATION

Parents Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Remarried

This office uses E-mail and Text messages for Appointment Reminders, You may Opt out of this by your request.

	FATHER	**MOTHER**
NAME:	______________	______________
Address: (If different from patient)	______________	______________
Cell Phone #	______________	______________
Social Security #	______________	______________
Employer Name:	______________	______________
Business Address:	______________	______________
Day Time Phone:	______________	______________
Occupation:	______________	______________
E-Mail Address: (Contact Address)	______________	______________
Responsible Party:	☐ ☐	☐

Orthodontic Insurance – Primary

Policy Holder Name: ______________

ID# ______________ Birth Date: ______________

Employer ______________

Please Present your Insurance Card to the Front Desk

Orthodontic Insurance – Secondary

Policy Holder Name: ______________

ID# ______________ Birth Date: ______________

Employer: ______________

Continued on Next Page

DENTAL HISTORY

How Often Do You Visit Your Family Dentist? 6 Months 12 Months Only When Needed

Is There Any Unfinished Dental Work to Be Done? NO **YES**______________________________

Has Your Child Had Any Facial or Dental Injuries? NO YES______________________________

Does Your Child Suck Their Thumb or Finger? NO YES How Often________________________

Has Your Child Seen an Orthodontist Before Now? NO YES, With Whom?_______________________

Have Any Other Children Had Orthodontic Treatment? NO YES, With Whom?_______________________

Names and Age of Siblings: ____

MEDICAL HISTORY

Physician's Name:________________Address:_____________________Phone # ____________

Does Your Child Require Antibiotics Before Dental Procedures? ....NO **YES** (Your Family Dentist will write a prescription When Needed)

Is Your Child Being Treated by a Physician for any Condition? …………NO YES (Please List Below)

Is Your Child Taking Any Medications? …………………………………NO YES (Please List Below)

Has Your Childs Tonsils Been Removed? ……………………………… NO YES

Does Your Child have any Allergies to Latex or Medications?..................NO **YES** (Please List Below)

Has Your Child had or have any of the Following?

Heart Murmur…………………… NO YES

Heart Surgery …………………… NO YES

Asthma ………………………… NO YES

Hepatitis………………………….. NO YES

Diabetes……………………………NO YES

Tuberculosis………………………NO YES

Growth Disorders……………………NO YES

Emotional Problems…………………..NO YES

Frequent Headaches…………………..NO YES

Bone Disorders………………………..NO YES

Mouth Breather………………………...NO YES

Prosthetic Joint Replacement…………NO YES

Please List All Medications Taken:

Please Describe Any Medical Conditions now being treated:

Is There Any Other Information About Your Child We Should Know?

Parent/Guardian Signature Reviewed By DATE

A Credit Rating will be obtained from Orthobanc LLC. for anyone requesting a payment plan with our office.

04/01/13