



PATIENT'S INFORMATION

Patient's Full Name _____ Patient prefers to be called: _____
Last First Middle

Patient's Address _____
Street City State Zip

Home Phone # _____ Cell or other Phone # _____

Patient's Date of Birth _____ Age _____ Male Female Single Married
Month Day Year Yrs. Mos.

Patient's Dentist _____ Date last visited _____

Whom may we thank for referring you to our office: _____

If Child, Father's Name _____
Mother's Name _____

Parent's Marital Status Married Single Divorced Widow Separated Remarried

Responsible Party Information

Name _____ Relationship: _____

Residence _____

Mailing Address _____

How long at this Address _____ Home Phone _____ Birthday _____

Previous Address (if less than three years) _____

Insurance Co: _____ Insurance ID# _____ Insurance Phone # _____

Spouses Name _____ Relationship to Patient _____

Employer _____ No. of Years Employed _____

Birthday _____ Work Phone _____

Health History

Medical History

Please check if patient has, or has had...

- Joint Swelling or Arthritis
- Bone Disorders
- Artificial Joints (Hip, Knee)
- Heart Problems
- Diabetes
- Thyroid Problems
- Kidney Problems
- Rheumatic Fever
- Scarlet Fever
- Hepatitis or Liver Problems
- Emotional Problems
- Nervous Disorders
- Tuberculosis
- Aids
(Acquired Immune Deficiency Syndrome/HIV Positive)
- Anemia
- Asthma
- Epilepsy / Convulsions
- Fainting
- Prolonged Bleeding
- Endocrine Problems
- Tonsils removed? If yes, when? _____
- Adenoids removed? If yes, when? _____

List any allergies _____

Is the patient under a physician's care presently? _____

Name _____

Reason _____

List any medications / dosage being taken presently: _____

List any other serious illness and operation not listed above: _____

Does the patient require pre-medication prior to dentist visits? _____

If so list medication/ dosage _____

Please list your chief concern(s) and what you would like treatment to accomplish _____

Dental History

Please check if patient has, or has had...

- Any injuries to face, mouth, teeth? (Circle)
- Thumb, finger or lip sucking habit(s)? (Previously / Currently) (Circle)
- Mouth breathing when asleep, awake? (Circle)
- Any known missing permanent teeth?
- Any know extra permanent teeth?
- Any teeth removed by extraction? When?
- Is there a tongue thrust problem?
- Any wind instruments played?
- Any clenching or grinding of teeth? (Circle)
- Any chronically sore or bleeding gums?
- Any pain or popping or locking on opening or closing jaw movement? (Circle)
- Frequent Headaches? If yes, headaches per week: _____
- Any muscle tenderness or stiffness in jaw or neck? (Circle)
- Any ringing sounds in the ear or spells of dizziness
- Any previous treatment for TMJ or jaw joint problems? If yes, explain. _____

Does the patient visit his/her dentist regularly? _____

Has the patient experienced a sudden increase in height?

Yes No

Has the patient reach puberty? Yes No

Does any member of the family or close member of the family have similar arrangement of teeth or similar appearance of jaws? _____

Does your dentist have any concerns? _____

Authorization

I have answered all the above questions to the best of my knowledge and understand the orthodontist will use this information to determine appropriate dental treatment for my child. I agree to notify the orthodontist of any changes to my child's health status immediately. I also authorized the dental staff to perform all necessary dental services for my child.

Signature _____