

DATE _____

PATIENT INFORMATION

Patient's Name _____
Prefer to be called _____ Age _____ Gender: F M
Birth date ____/____/____ Home Phone _____ School _____ Grade _____
Home Address _____ City, State _____ Zip _____
Patient's hobbies/sports/instruments _____
Names and ages of other children in family _____
Names of other children in family previously treated by us _____
General Dentist _____ Date of last cleaning (Mo/Year) _____
Whom may we thank for referring you to our office? _____
Who is accompanying you child today? Name _____ Relation _____
If transferring, previous DDS _____

FATHER'S INFORMATION

Name _____ Legal Custody ___ Yes ___ No
Check if Applicable Stepfather Guardian Marital Status _____
Home Address _____ City, State _____ Zip _____
Own [] Rent [] Previous Address (if less that 3 years) _____
Home Phone _____ Work Phone _____
Cell Phone _____ E-mail _____
Employer _____ Occupation _____ No. Years Employed _____
Dental insurance through current employer ___ Y ___ N **Expected Ortho Benefit \$** _____
Dental Insurance Company _____ Group # _____
Address _____ Phone _____
Insured's Birth date ____/____/____ ID # _____ Social Security # _____

MOTHER'S INFORMATION

Name _____ Legal Custody ___ Yes ___ No
Check if Applicable Stepmother Guardian Marital Status _____
Home Address (If different) _____ City, State _____ Zip _____
Own [] Rent [] Previous Address (if less that 3 years) _____
Home Phone _____ Work Phone _____
Cell Phone _____ E-mail _____
Employer _____ Occupation _____ No. Years Employed _____
Dental insurance through current employer ___ Y ___ N **Expected Ortho Benefit \$** _____
Dental Insurance Company _____ Group # _____
Address _____ Phone _____
Insured's Birth date ____/____/____ ID # _____ Social Security # _____

EMERGENCY CONTACT

Name of nearest **relative not living with you** (Relationship) _____
Address _____ Home Phone _____
City, State _____ Zip _____ Alternate Phone _____

PLEASE COMPLETE REVERSE SIDE

HEALTH HISTORY

Please check box if patient has (or had) any of the following:

- | | | | | | |
|--------------------------------|--------------------------|----------------------------|--------------------------|-----------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | Endocrine/Thyroid problem | <input type="checkbox"/> | Liver/Kidney Problem | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | Nervous/Hyperactive | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Fever Blisters/Herpes | <input type="checkbox"/> | Prolonged Bleeding | <input type="checkbox"/> |
| Blood Transfusion | <input type="checkbox"/> | Frequent Headaches | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> |
| Bone Disorder/Osteoporosis | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | Tobacco Use | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Handicaps/Disabilities | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Convulsions | <input type="checkbox"/> | Hearing Problems | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> |
| Emotional Problems | <input type="checkbox"/> | Heart Problems | <input type="checkbox"/> | Removal of Tonsils/Adenoids | <input type="checkbox"/> |
| Artificial Bones/Joints/Valves | <input type="checkbox"/> | HIV (tested positive)/Aids | <input type="checkbox"/> | | |

ANY ALLERGIES TO: Latex Metal/Nickel Plastic Penicillin Peanuts

Child's Physician _____ **Phone #:** () _____

Routinely need pre-medication before dental procedures **YES / NO**

Is patient under physician's care? **YES / NO**

If so, for what reason _____

Is patient taking prescription medications? **YES / NO**

If so, please list _____

For children and adolescence only:

Has puberty been reached? **YES / NO**

If so, has it been within the last two years? **YES / NO**

List any additional health related issues _____

DENTAL HISTORY

- | | YES | NO |
|---|--------------------------|--|
| Any congenitally missing teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any extra teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any primary/permanent teeth been extracted? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has patient ever sucked thumb or finger? | <input type="checkbox"/> | <input type="checkbox"/> (How old when stopped? _____) |
| Clicking or pain when opening jaws? TMJ Problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any night-time clenching or grinding habit? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any speech problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent mouth breathing? (awake/sleeping) | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any sibling had orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has either parent had orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Surgery to repair cleft lip and/or cleft palate? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has patient ever seen an Orthodontist? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has patient been ridiculed about appearance of teeth? | <input type="checkbox"/> | <input type="checkbox"/> |

What are the main concerns you would like orthodontics to accomplish?

I confirm the information I have given is correct and I authorize the dental staff to perform the necessary dental services my child may need.

Signature (parent guardian if minor) _____ **Date** _____