

Patient Information:

Male Female

Today's date ____/____/____

Name _____

Birthdate ____/____/____

Name he or she likes to be called _____ Patient's Email _____

Home Address _____

Home (____) - ____ - ____ Patient's Cell (____) - ____ - ____

School _____ Grade _____

Sports/Hobbies _____

of brothers _____ Age(s) _____ # of sisters _____ Age(s) _____

Physician's Name _____ Dentist's Name _____

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

Briefly describe the problem and/or reason for seeking an orthodontic evaluation: _____

Relationship to patient: Mother Stepmother Guardian Other _____

Mrs Ms Dr Name _____ DOB ____/____/____

Home (____) - ____ - ____ Work (____) - ____ - ____ Cell (____) - ____ - ____

Employer _____ Email _____

Relationship to patient: Father Stepfather Guardian Other _____

Mr. Dr Name _____ DOB ____/____/____

Home (____) - ____ - ____ Work (____) - ____ - ____ Cell (____) - ____ - ____

Employer _____ Email _____

Person Responsible for this Account:

Name _____ Relationship _____

Billing Address _____ SS # ____ - ____ - ____

Employer _____ Work (____) - ____ - ____

Appointment Reminders: A maximum of 4 appointment reminders can be sent (2 email, 2 text). Please check the box next to any (patient and/or responsible party below) you would like reminders sent to.

MEDICAL HISTORY

Has the patient been diagnosed or treated for any of the following?

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Endocrine Disorder |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Emotional Difficulties |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Heart Trouble |

Yes No

- Is the patient adopted? At what age? _____
- Have antibiotics been recommended for dental visits?
- Is the patient allergic to anything? If so what? _____
- Have the tonsils or adenoids been removed?
- Is the patient presently under the care of a physician? For? _____
- Is the patient taking any medications? _____
- Has the patient had any major surgery? For? _____
- Does the patient have a chronic problem with:
- Kidney Heart Lungs Liver

Has the patient reached puberty?

Yes No

- Menstruated (girls) Approx. date _____
- Voice Change (boys) Approx. date _____

Are there any other medical problems not mentioned above or additional information we should know about?

Describe: _____

DENTAL HISTORY

Yes No

- Has the patient ever sucked his/her thumb or fingers? Until what age? _____
- Does the patient breathe predominantly through his/her mouth?
- Does the patient have any speech problems?
- Does the patient clench or grind teeth at night or during the day?
- Does the patient experience jaw joint clicking or pain upon opening or closing his/her mouth?
- Has the patient had any severe head or face injuries?
- Have any teeth been injured or chipped? When? _____
- Has a dentist informed you or the patient of any extra teeth or missing teeth?
- Were any teeth (baby or permanent) removed by extraction?
- Has a dentist ever placed a retainer or space maintainer?
- Has any member of your family had orthodontic treatment? Who? _____
- Has the patient had any previous orthodontic consultations or treatment?
- Does anyone in the family have a similar dental condition?
- Would the patient mind wearing braces?
- Would the patient mind wearing headgear?
- Has the patient had any noticeable difficulty in chewing or swallowing food?
- Has the patient ever been teased about the appearance of his/her teeth?
- Is the patient concerned about the appearance of his/her teeth?
- Does the patient want his/her teeth straightened?
- Are you aware that some appointments will infringe on school time?

Approx. date of last dental appointment: _____

The above information is true and correct and I have received a copy of this office's Notice of Privacy Policy.

Parent/Resp. Party signature _____ Date _____