PERSONAL INFORMATION – CHILD (under 18 yrs. of age)

Date_____

Patient's Name_____Nickname_____Sex_____
Last First Middle

Patient's Address_____
Street City State Zip Code

Patient's Home Phone_____Date of Birth_____Age_____Grade____

Patient's E-Mail Address_____Parent's E-Mail Address_____

School_____Patient's Favorite Sports, Hobbies, Avocations_____

Dentist_____Physician_____Musical Instruments Played_____

Father's Name_____Social Security No._____
Last First Middle

Father's Address_____Occupation_____
(If different from patient's address)

Employer's Name & Address_____

Business Phone No. _____Length of Emp._____

Mother's Name_____ Social Security No._____
Last First Maiden

Mother's Address_____Occupation_____
(If different from patient's address)

Employer's Name & Address_____

Business Phone No. _____ Length of Emp._____

Parents are: Single_____Married_____Widowed_____Separated_____Divorced_____Other_____

Other Family Members Seen In Our Office:_____

Brother(s) #_____ Age(s) ( ) ( ) ( ) ( ) Sister(s) #_____Age(s) ( ) ( ) ( ) ( )

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

In case we cannot reach you, person to contact_____Phone No._____

YES NO **Insurance Coverage for Orthodontics (If Yes, please fill out last page)**
YES NO Does patient brush his/her teeth conscientiously?
YES NO Does patient have learning disabilities or need extra help with instructions?
YES NO Is patient sensitive, self-conscious?
YES NO Does patient follow directions?

For the following questions, circle YES or NO. The answers are for office records and will be considered CONFIDENTIAL. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

Yes No Birth defects or hereditary problems?
Yes No Bone fractures, any major accidents?
Yes No Rheumatoid or arthritic conditions?
Yes No Endocrine or thyroid problems?
Yes No Kidney problems?
Yes No Diabetes?
Yes No Cancer or been treated for a tumor?
Yes No Stomach ulcer or hyperacidity?
Yes No Polio, mononucleosis, tuberculosis, pneumonia?
Yes No Problems of the immune system?
Yes No Hepatitis, jaundice or liver problem?
Yes No AIDS or HIV positive?
Yes No Sexually transmitted disease?
Yes No Fainting spells, seizures, epilepsy or neurologic disease?
Yes No Mental health or behavioral problems?
Yes No Vision, hearing, tasting or speech difficulties?
Yes No Loss of weight recently, poor appetite?
Yes No Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
Yes No High or low blood pressure?
Yes No Tires easily?
Yes No Chest pain, shortness of breath or swelling ankles?
Yes No **Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints?**
Yes No Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke?
Yes No Skin disorder?
Yes No Does patient have a normal and good diet?
Yes No Frequent headaches, colds or sore throat?
Yes No Eye, ear, nose, throat conditions?
Yes No Hayfever, asthma, sinus trouble, hives?
Yes No Tonsil or adenoid conditions?
Yes No Allergies or drug reactions?_____
Yes No Is patient taking medication, nutrient supplements or nonprescription medicine? Please name them_____
Yes No Operations? (surgical procedures)?
Yes No Hospitalized? For?_____
Yes No Other physical problems or symptoms?
Yes No Being treated by another health care professional? For?_____
Date of most recent physical exam_____

FEMALE PATIENTS ONLY

Yes No Has patient started her menstrual period? If yes, at what age?_____
Yes No Is patient pregnant?

DENTAL HISTORY

Yes No Started teething very early or late?
Yes No Primary (baby) teeth removed that were not loose?
Yes No Permanent or "extra" (supernumerary) teeth removed?
Yes No Supernumerary (extra) or congenitally missing teeth?
Yes No Chipped or otherwise injured primary (baby) or permanent teeth?
Yes No Teeth sensitive to hot or cold; teeth throb or ache?
Yes No Jaw fractures, cysts, mouth infections?
Yes No "Dead Teeth", tooth canals treated?
Yes No Bleeding gums, bad breath, mouth odor?
Yes No Periodontal "Gum Problems"?
Yes No Food impaction between teeth?
Yes No "Gum Boils", frequent canker sores, cold sores?
Yes No Is patient taking any forms of fluoride?
Yes No Thumb, finger, sucking habit? Until _____
Yes No Abnormal swallowing habit (tongue thrusting)?
Yes No History of speech problems?
Yes No Mouth breathing habit, snoring, difficulty in breathing?
Yes No Tooth grinding, jaw clenching, clicking, locking?
Yes No Any pain in jaw or ringing in the ears?
Yes No Does the patient experience any pain or soreness in the muscles of the face, or around the ears?
Yes No Difficulty encountered in chewing or jaw opening?
Yes No Aware of loose, broken or missing restorations (fillings)?
Yes No Any teeth irritating cheek, lip, tongue, palate?
Yes No Concerned about spaced, crooked, protruding teeth?
Yes No Aware or concerned about under or over developed jaw?
Yes No Any relative with similar tooth or jaw relationships?
Yes No Any wisdom tooth problems?
Yes No Has patient had any serious trouble associated with any previous dental treatment?
Yes No Onset of puberty (approximate date)?
Yes No Has patient ever had a prior orthodontic examination or treatment?
Yes No Has patient recently been under another dentist's care? Name_____
Yes No Has patient ever had periodontal (gum) treatment?
Yes No Would patient object to wearing orthodontic appliances (braces) should they be indicated?

Date of most recent dental examination_____

How often does patient brush_____ Floss_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

Signature of parent or guardian Date

PATIENT INSURANCE INFORMATION FORM

PATIENT NAME:_____DATE OF BIRTH:_____

INSURED PERSON:_____DATE OF BIRTH:_____

INSURED PERSON'S SOCIAL SECURITY NUMBER:_____

PATIENT RELATIONSHIP TO INSURED:_____

INSURANCE COMPANY NAME & ADDRESS:_____

_____

INSURANCE COMPANY PHONE NUMBER:_____

GROUP NUMBER:_____

EMPLOYER NAME & ADDRESS:_____

EMPLOYER PHONE NUMBER:_____

IS PATIENT COVERED BY ANOTHER PLAN? IF YES, FILL OUT BELOW

NAME OF INSURED:_____DATE OF BIRTH:_____

INSURED PERSON'S SOCIAL SECURITY NO.:_____

RELATIONSHIP TO PATIENT:_____

INSURANCE COMPANY NAME AND ADDRESS:_____

_____

INSURANCE COMPANY PHONE NUMBER:_____

GROUP NUMBER:_____

EMPLOYER NAME & ADDRESS:_____

EMPLOYER PHONE NUMBER:_____