

**ORTHODONTIC PATIENT INFORMATION**

Welcome to our office,

The following information is requested to enable us to give the best consideration of your child's orthodontic problem during your initial examination in our office. In order for us to thoroughly diagnose any condition, we must have accurate background and health information on which to base our decisions. This information, important for our records and your health, is confidential. Please circle the appropriate response where indicated. Thank you.

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

General Dentist \_\_\_\_\_ Phone no \_\_\_\_\_  
Physician \_\_\_\_\_ Referred By \_\_\_\_\_

Patient's School and Grade Level \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Bus Phone \_\_\_\_\_

Is patient covered by insurance for orthodontic treatment? Yes No  
If yes, by which company? \_\_\_\_\_

Name of person to be contacted if patient or parent cannot be reached:  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Family Status  
Siblings \_\_\_\_\_ Number of Brothers \_\_\_\_\_ Number of Sisters \_\_\_\_\_  
Father's Name \_\_\_\_\_  
Mother's Name \_\_\_\_\_  
Other family members with similar orthodontic condition?  
Father Brother Other  
Mother Sister Specify Condition \_\_\_\_\_

Medical & Dental History:  
Present Health      Good    Fair    Poor      Under Medical Treatment:    Yes    No  
Specify \_\_\_\_\_  
Has patient been under care of a physician during the past two years other than for routine examination?  
Yes    No    Specify \_\_\_\_\_  
Drugs or medication currently being taken? \_\_\_\_\_ Yes    No  
Specify \_\_\_\_\_  
Has patient ever been treated in a hospital? \_\_\_\_\_ Yes    No  
Specify \_\_\_\_\_  
Has patient ever been treated in an emergency room? \_\_\_\_\_ Yes    No  
Specify \_\_\_\_\_  
Birth Defects \_\_\_\_\_ Yes    No  
Specify \_\_\_\_\_  
Has patient reached puberty? \_\_\_\_\_ Yes    No  
Has patient had any recent rapid growth? \_\_\_\_\_ Yes    No

(Over)

Has the patient ever had:

Asthma  
Anemia  
Arthritis  
Bleeding Problems  
Blood Disease  
Bone Disorders

Cleft Lip or Palate  
Diabetes  
Epilepsy  
Endocrine Problems  
Emotional Problems  
Head or Face Injury

Heart Disease  
Hepatitis  
Kidney Disease  
Rheumatic Fever  
Speech or Hearing Disorder

Comments: \_\_\_\_\_  
\_\_\_\_\_

Does the patient:

1. Have allergies to: Seasonal Grasses \_\_\_\_\_ Food \_\_\_\_\_  
Drugs \_\_\_\_\_ Other \_\_\_\_\_
2. Snores when sleeping? Yes No
3. Breath through mouth? Seldom Sometimes Usually Comments: \_\_\_\_\_
4. Have frequent colds? Yes No
5. Have frequent sore throat or tonsillitis? Yes No
6. Have chewing or swallowing difficulty? Yes No

Has patient received medical treatment from allergist or ear, nose or throat specialist? Yes No  
If yes: When \_\_\_\_\_ By Whom \_\_\_\_\_  
Age Tonsils Removed \_\_\_\_\_ Age Adenoids Removed \_\_\_\_\_

Does the patient have frequent headaches? Yes No  
Does the patient have pain or clicking in jaw joint? Yes No  
Have any teeth been injured due to accidents or blows to the mouth? Yes No  
Has the patient received or been requested to receive speech correction? Yes No

The following habits are of interest to the orthodontist. List information as it pertains to this patient:

Thumb sucking until age \_\_\_\_\_ Grinding of teeth Yes No  
Finger sucking until age \_\_\_\_\_ Tongue thrusting Yes No  
Lip-biting or sucking Yes No Other habits \_\_\_\_\_

Has the patient has any unusual dental experiences? Yes No  
Specify \_\_\_\_\_

Has the patient had previous orthodontic consultation or treatment? Yes No  
Date \_\_\_\_\_ Dr. \_\_\_\_\_

Are there any other medical, dental or surgical problems not covered above? Yes No

Dental checkups usually Twice a Year Once a Year  
Date of last dental checkup \_\_\_\_\_ At that time, were the patient's teeth cleaned? Yes No

Is the patient aware of any orthodontic problem? Yes No  
Patient's interest in orthodontic treatment:  
The Patient Wants Treatment Treatment is Necessary Unwilling but agrees Uncooperative

Orthodontic Consultation prompted by: Patient Dentist Mother Father Spouse  
Sibling Physician Friend Other (specify) \_\_\_\_\_

Reason for seeking treatment: \_\_\_\_\_  
\_\_\_\_\_

Signature of individual completing this form: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Today's Date \_\_\_\_\_