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**_____

Birth date_____

Address_____ **Home Phone**_____

Occupation_____ **Employer**_____ **Bus Phone**_____

Insurance Company_____ **ID#**_____

Group #_____

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	**Cleft Lip or Palate**	**Heart Disease**
Anemia	**Diabetes**	**Hepatitis**
Arthritis	**Epilepsy**	**Kidney Disease**
Bleeding Problems	**Endocrine Problems**	**Rheumatic Fever**
Blood Disease	**Emotional Problems**	**Speech or Hearing Disorder**
Bone Disorders	**Head or Face Injury**	

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**_____