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 _____ BIRTHDATE _____ SEX____

HOME ADDRESS _____ HOME PHONE _____

E-MAIL _____

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 _____

DENTIST _____ PHYSICIAN _____ REFERRED BY _____

ADDRESS OF DENTIST _____ 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. Snore when sleeping? Yes No
3. Breath through mouth? Seldom Sometimes Usually COMMENTS: _____
4. Have frequent colds? Yes No
5. Have frequent sore throat or tonsilitis? Yes No
6. Have chewing or swallowing difficulty? Yes No

Has patient received medical treatment from allergist or ear, nose and throat specialist?

Yes No If YES: When _____ By Whom _____

Age Tonsils Removed _____ Age Adenoids Removed _____

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 Yes No

Has the patient had 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 If 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 _____