PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's name _____

Address_____

_____

Nickname_____ Birthdate_____

School_____

Sports/Hobbies_____

Parent or guardian name_____

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

RESPONSIBLE PARTY INFORMATION

Name_____

Address_____

_____

Mailing Address if different_____

_____

Home phone_____ Work phone _____

Cell phone_____ Email address_____

Relationship to Patient_____

Employer_____ Occupation_____

Spouse's Name_____

Relationship to Patient _____

Employer_____ Occupation_____

Work Phone _____Cell phone_____

MEDICAL HISTORY

Physician_____ Date of Last Visit_____

Address_____ Phone_____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication?

Yes No Is the patient allergic to any medication?

Yes No History of a major illness?

Yes No Has the patient had any operations?

Yes No Ever been involved in a serious accident?

Yes No Have seen a physician in the last 12 months? Why?

Female Patients only:
Yes No Has menstruation started?

Yes No Is the patient pregnant?

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes
Pneumonia	Hepatitis/Liver problems
Anemia	Dizziness
Prolonged Bleeding	Herpes
Arthritis	Epilepsy
Radiation/Chemotherapy	High Blood Pressure
Asthma or Hayfever	Gastrointestinal Disorders
Rheumatic Fever	HIV / Aids
Bone Disorders	Heart Problems
Tuberculosis	Kidney problems
Congenital Heart Defect	Heart Murmur
Tumor or Cancer	Nervous Disorders

Are there any medical conditions we have not discussed that you feel we should be aware of?

DENTAL HISTORY

General Dentist_____ Date of last visit_____

What concerns you most about your teeth?_____

Yes No Is the patient presently in any dental pain?

Yes No Ever experienced any unfavorable reaction to dentistry?

Yes No Has the patient ever lost or chipped any teeth?

Yes	No	Have there been any injuries to face, mouth, or teeth?
Yes	No	Is any part of your mouth sensitive to temperature? Where?
Yes	No	Is any part of your mouth sensitive to pressure? Where?
Yes	No	Do gums bleed when brushing?
Yes	No	Any type of thumb or tongue habit?
Yes	No	Is the patient a mouth breather?
Yes	No	Has the patient ever seen an orthodontist? If yes, when?
Yes	No	What is the patient's attitude toward receiving orthodontic treatment?
Yes	No	Has anyone in the family received orthodontic treatment?
		How did they feel about the result?
Yes	No	Do teeth or jaws ever feel uncomfortable first thing in the morning?
Yes	No	Experience jaw clicking or popping?
Yes	No	Aware of clenching or grinding teeth during the day?
Yes	No	Experience "tension" headaches?
Yes	No	Has the patient ever experienced chronic ringing in the ears?
Yes	No	Does the patient need extra help with instructions?
Yes	No	Is the patient sensitive or self-conscious about his/her teeth?
Yes	No	Are you aware that some appointments will be during school hours?

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

Signature:_____

Date:_____