PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date____________________

Patient's name ____
Last First Middle

Address ____
Street City Zip

Nickname______________________ Birthdate_______________ Number of other children in the family_________________________

School___________________________ Sports/Hobbies____

Parent or guardian name ____

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

RESPONSIBLE PARTY INFORMATION

Name ____
Last First Middle

Mailing Address ____
Street City Zip

Home phone #__________________________________ Work phone# ____

Cell/other phone_________________________ Email address____

Relationship to Patient ____________________ Parent's marital status (circle) S M D W

DENTAL INSURANCE INFORMATION

Insured's Name____ Insured's Social Security #/ ID # _________________________

Insurance Company_________________________ Group No._________________ Local No. ________________________________

Insurance Co. Address____ Phone No._______________________________

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name____ Insured's Social Security #/ ID # ___________________________

Insurance Company_________________________ Group No._________________ Local No. ________________________________

Insurance Co. Address____ Phone No._______________________________

EMERGENCY INFORMATION

Name of nearest relative not living with you____

Complete address ____
Street City Zip

Phone____

MEDICAL HISTORY

Physician ____Date of Last Visit_____________________________

Address ____Phone ____________________________________

Is there any history of: (Please circle)

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

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

Are you under a physician's care presently Y – N What condition?____

Do you have any allergies? Y – N What? Penicillin, Latex, Metals, Food, etc. _____________________________________

Are you taking any medications? Y- N What? ____

Have you ever been involved in a serious accident? Y - N ____

Have you had any operations? Y- N ____

Female Patients (Please circle) Has menstruation started? Y - N If yes, when_____________________

Is the patient pregnant? Y - N

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 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, who and when? __________________________________
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 Is the patient sensitive or self-conscious about his/her teeth? ______________________________________
Yes No Height of parents? Mom______ Dad______
Yes No Are you aware that some appointments will be during school hours?

DENTAL FINDINGS (To be completed by the orthodontist)

Molar **R**: I II III **L**: I II III

Canine **R**: I II III **L**: I II III

Crowding U L

Spacing U L

Midlines **U**: R L **L:** R L

Overjet mild, moderate , severe, negative _____mm

Overbite mild, moderate, severe, open ______mm

Crossbites Posterior **R** **L** Anterior

Habits

Impactions

Oral hygiene/ Decalcifications

Facial symmetry

Arch form

TMJ

Missing teeth

WFE **RECALL __________months**

Tentative Treatment Plan:

Patient's Next Step:

Est. time
Est. fee