

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_  
Prefer to be called \_\_\_\_\_ Age \_\_\_\_\_ Gender: F M  
Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
Home Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_  
Patient's hobbies/sports/instruments \_\_\_\_\_  
Names and ages of other children in family \_\_\_\_\_  
Names of other children in family previously treated by us \_\_\_\_\_  
General Dentist \_\_\_\_\_ Date of last cleaning (Mo/Year) \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_  
Who is accompanying you child today? Name \_\_\_\_\_ Relation \_\_\_\_\_  
If transferring, previous DDS \_\_\_\_\_

## FATHER'S INFORMATION

Name \_\_\_\_\_ Legal Custody \_\_\_ Yes \_\_\_ No  
Check if Applicable  Stepfather  Guardian Marital Status \_\_\_\_\_  
Home Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_  
Own [ ] Rent [ ] Previous Address (if less that 3 years) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_  
Dental insurance through current employer \_\_\_ Y \_\_\_ N **Expected Ortho Benefit \$** \_\_\_\_\_  
Dental Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Insured's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ ID # \_\_\_\_\_ Social Security # \_\_\_\_\_

## MOTHER'S INFORMATION

Name \_\_\_\_\_ Legal Custody \_\_\_ Yes \_\_\_ No  
Check if Applicable  Stepmother  Guardian Marital Status \_\_\_\_\_  
Home Address (If different) \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_  
Own [ ] Rent [ ] Previous Address (if less that 3 years) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_  
Dental insurance through current employer \_\_\_ Y \_\_\_ N **Expected Ortho Benefit \$** \_\_\_\_\_  
Dental Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Insured's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ ID # \_\_\_\_\_ Social Security # \_\_\_\_\_

## EMERGENCY CONTACT

Name of nearest **relative not living with you** (Relationship) \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City, State \_\_\_\_\_ Zip \_\_\_\_\_ Alternate Phone \_\_\_\_\_

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## HEALTH HISTORY

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**Please check box if patient has (or had) any of the following:**

- |                                |                          |                            |                          |                             |                          |
|--------------------------------|--------------------------|----------------------------|--------------------------|-----------------------------|--------------------------|
| Allergies                      | <input type="checkbox"/> | Endocrine/Thyroid problem  | <input type="checkbox"/> | Liver/Kidney Problem        | <input type="checkbox"/> |
| Anemia                         | <input type="checkbox"/> | Fainting                   | <input type="checkbox"/> | Nervous/Hyperactive         | <input type="checkbox"/> |
| Asthma                         | <input type="checkbox"/> | Fever Blisters/Herpes      | <input type="checkbox"/> | Prolonged Bleeding          | <input type="checkbox"/> |
| Blood Transfusion              | <input type="checkbox"/> | Frequent Headaches         | <input type="checkbox"/> | Rheumatic Fever             | <input type="checkbox"/> |
| Bone Disorder/Osteoporosis     | <input type="checkbox"/> | Glaucoma                   | <input type="checkbox"/> | Tobacco Use                 | <input type="checkbox"/> |
| Cancer                         | <input type="checkbox"/> | Handicaps/Disabilities     | <input type="checkbox"/> | Tuberculosis                | <input type="checkbox"/> |
| Convulsions                    | <input type="checkbox"/> | Hearing Problems           | <input type="checkbox"/> | Hepatitis                   | <input type="checkbox"/> |
| Emotional Problems             | <input type="checkbox"/> | Heart Problems             | <input type="checkbox"/> | Removal of Tonsils/Adenoids | <input type="checkbox"/> |
| Artificial Bones/Joints/Valves | <input type="checkbox"/> | HIV (tested positive)/Aids | <input type="checkbox"/> |                             |                          |

**ANY ALLERGIES TO:**     Latex         Metal/Nickel         Plastic         Penicillin         Peanuts

**Child's Physician** \_\_\_\_\_ **Phone #:** (    ) \_\_\_\_\_

Routinely need pre-medication before dental procedures    **YES / NO**

Is patient under physician's care?    **YES / NO**

If so, for what reason \_\_\_\_\_

Is patient taking prescription medications?    **YES / NO**

If so, please list \_\_\_\_\_

For children and adolescence only:

Has puberty been reached?    **YES / NO**

If so, has it been within the last two years?    **YES / NO**

List any additional health related issues \_\_\_\_\_

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## DENTAL HISTORY

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- |   | YES                      | NO   |
|---|--------------------------|--|
| Any congenitally missing teeth?                       | <input type="checkbox"/> | <input type="checkbox"/>                               |
| Any extra teeth?                                      | <input type="checkbox"/> | <input type="checkbox"/>                               |
| Have any primary/permanent teeth been extracted?      | <input type="checkbox"/> | <input type="checkbox"/>                               |
| Has patient ever sucked thumb or finger?              | <input type="checkbox"/> | <input type="checkbox"/> (How old when stopped? _____) |
| Clicking or pain when opening jaws? TMJ Problems?     | <input type="checkbox"/> | <input type="checkbox"/>                               |
| Any night-time clenching or grinding habit?           | <input type="checkbox"/> | <input type="checkbox"/>                               |
| Any speech problems?                                  | <input type="checkbox"/> | <input type="checkbox"/>                               |
| Frequent mouth breathing? (awake/sleeping)            | <input type="checkbox"/> | <input type="checkbox"/>                               |
| Has any sibling had orthodontic treatment?            | <input type="checkbox"/> | <input type="checkbox"/>                               |
| Has either parent had orthodontic treatment?          | <input type="checkbox"/> | <input type="checkbox"/>                               |
| Surgery to repair cleft lip and/or cleft palate?      | <input type="checkbox"/> | <input type="checkbox"/>                               |
| Has patient ever seen an Orthodontist?                | <input type="checkbox"/> | <input type="checkbox"/>                               |
| Has patient been ridiculed about appearance of teeth? | <input type="checkbox"/> | <input type="checkbox"/>                               |

**What are the main concerns you would like orthodontics to accomplish?**

\_\_\_\_\_

I confirm the information I have given is correct and I authorize the dental staff to perform the necessary dental services my child may need.

**Signature (parent guardian if minor)** \_\_\_\_\_ **Date** \_\_\_\_\_