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Patient Information

Name: ______ Date of Birth: ______ Age: ______
Address: ______ City: ______ State: ______ Zip: ______
Telephone: (home) ______ (work): ______ (cell): ______
E-mail address: ______
Occupation: ______ Business Phone: ______ Social Sec. # ______
Employer: ______ Address: ______
Medical Insurance Carrier: ______
Orthodontic Insurance Carrier: ______
Family Dentist: ______ Telephone: ______ Address: ______
Family Physician: ______ Telephone: ______ Address: ______
School: ______ Telephone: ______ Grade: ______
Sports, etc. ______
Brothers and Sisters: Name: ______ Age: ______ Name: ______ Age: ______
Name: ______ Age: ______ Name: ______ Age: ______
Family members with similar dental conditions: ______
Family members who have had orthodontic treatment: ______
Have you seen another orthodontist: ______ Name: ______

Patient/Parent/Guardian Information

Married: ______ Living Together: ______ Divorced : ______ Separated: ______ Father Deceased: ______ Mother Deceased: ______ Child Lives With: ______

Father's Name: ______ Date of Birth: ______ Origin: ______
Address: ______ City: ______ State: ______ Zip: ______
Cell Phone: ______ E-mail Address: ______
Occupation: ______ Business Phone: ______ Social Sec. # ______
Employer: ______ Address: ______
Medical Insurance Carrier: ______
Orthodontic Insurance Carrier: ______

Mother's Name: ______ Date of Birth: ______ Origin: ______
Address: ______ City: ______ State: ______ Zip: ______
Cell Phone: ______ E-mail Address: ______
Occupation: ______ Business Phone: ______ Social Sec. # ______
Employer: ______ Address: ______
Medical Insurance Carrier: ______
Orthodontic Insurance Carrier: ______

MEDICAL HISTORY

General Health __ Poor __ Fair __ Good __ Excellent
Birth Defects ____
Presently under medical care for ____________________________________
Drugs or medication being taken now (Drug and Dosage) ______________________
Allergic to what drugs ____

PLEASE CHECK YES OR NO TO THE FOLLOWING AND DATE

	Yes	No		Yes	No		Yes	No
Adenoids removed	__	__	Heart Disorder	__	__	Congenial heart disease	__	__
AIDS	__	__	Hepatitis	__	__	Convulsions	__	__
Allergies	__	__	Hospitalized	__	__	Diabetes	__	__
Anemia	__	__	Hyperactivity	__	__	Dizziness	__	__
Arthritis	__	__	Hypertension	__	__	Emotional	__	__
Asthma	__	__	Injuries	__	__	Endocrine disorder	__	__
Blood disorder	__	__	Jaundice	__	__	Epilepsy	__	__
Bone disorder	__	__	Kidney disorder	__	__	Nosebleeds	__	__
Breathing difficulties	__	__	Liver disorder	__	__	Eye disorders	__	__
Bronchitis	__	__	Lung disorder	__	__	Fainting spells	__	__
Chicken pox	__	__	Measles	__	__	Glaucoma	__	__
Cerebral palsy	__	__	Mumps	__	__	Hearing difficulties	__	__
Neurosis	__	__	Polio	__	__	Rheumatic fever	__	__
Scoliosis	__	__	Seizures	__	__	Speech difficulties	__	__
X-ray treatment (not diagnostic)	__	__	Tonsils(removed)	__	__	Tuberculosis	__	__
			Venereal disease	__	__	Pregnant/Poss. Pregnant	__	__

Other ____
Please give greater details where necessary ______________________________

SEXUAL MATURATION

Female patients: Monthly periods __ Yes __ No Started at age ____ yrs. ____ mos.
Other indications of pubertal development ______________________________
Male patients: Voice change __ Yes __ No Facial hair growth __ Yes __ No
Other indications of pubertal development ______________________________

DENTAL HISTORY

Date of last dental check-up __________ Does water in your area contain fluoride __ Yes __ No
Injuries or trauma to the face or teeth ______________________________
Brushing teeth several times a day _____ once a day, nearly every day _____ rarely _____
Does the patient play a musical instrument ______________________________
Thumb sucking __ Yes __ No Discontinued at age ____ Other habits __________
Breathing: nose __________ mouth __________ Difficulty at night __________
Mouth: usually __________ frequently open __________ seldom open __________
Infections: none __________ ear __________ nose __________ throat __________
Bruxism: grinds teeth __ Yes __ No at night ____ daytime ____
Speech difficulty in pronunciation __ Yes __ No Speech lessons __ Yes __ No
Why are you seeking orthodontic treatment ______________________________
Questionnaire completed by __________ Relation to patient __________ Referred by ______