

PATIENT INFORMATION FORM FOR CHILDREN

FULL NAME _____ Nick Name _____
School _____ Grade _____ Date of Birth _____ Age _____ Sex: Male _____ Female _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Mom Cell # _____ Dad Cell# _____
E-Mail Address _____
General Dentist _____ Referred By: _____

PARENTS INFORMATION

Father's Full Name _____ Date of Birth _____
SS# _____ Married _____ Divorced _____ Separated _____ Widowed _____
Place of Employment _____ Occupation _____
Business Address _____ Phone _____
City State Zip
Home Address _____ Phone _____
City State Zip
Mother's Full Name _____ Date of Birth _____
SS _____ Married _____ Divorced _____ Separated _____ Widowed _____
Place of employment _____ Occupation _____
Business Address _____ Phone _____
City State Zip
Home Address _____ Phone _____
City State Zip

Names and ages of other children in family _____

If you have moved within the last two years, list previous address. _____

Dental Insurance name and address _____

Insured's Name _____ ID# _____ Group# _____

Authorization:

I authorize my insurance company to pay to the orthodontist or orthodontic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Relationship to patient _____

HEALTH QUESTIONNAIRE

DATE _____

NAME _____

1. Does the patient have regular Dental-Medical examinations? _____ Yes No
Last Dental Appt. and Procedures? _____
Date of last dental x-rays? _____
2. Has there been any change in the patient's general health within the past year? _____ Yes No
If yes explain: _____

3. Name and address of family physician: _____
Is the patient currently under treatment and if so for what condition? _____
4. Please list any prescription medications patient is taking _____

5. Has the patient been hospitalized or had any serious illness and if so for what condition, illness or operation?
6. Does the patient have or had any of the following? _____ Yes No
 - A. Scarlet Fever, Rheumatic Fever/Heart Disease? _____ Yes No
 - B. Congenital Heart Lesions? _____ Yes No
 - C. Mitral Valve Prolapse/ Heart Murmur? _____ Yes No
 - D. Allergies to Drugs, Anesthetics, or Other? _____ Yes No
Please Specify _____
 - E. Sinus problems, Hay Fever, Asthma? _____ Yes No
 - F. Epilepsy, Cerebral or Spastic Condition? _____ Yes No
 - G. Blood Disorder (Anemia, Hemophilia)? _____ Yes No
 - H. Herpes? _____ Yes No
 - I. Hepatitis? _____ Yes No
Please Specify _____
 - J. Tuberculosis? _____ Yes No
 - K. HIV/AIDS? _____ Yes No
 - L. Latex Allergies? _____ Yes No
7. Has the patient come in contact with someone with Hepatitis, Tuberculosis, or HIV/AIDS? _____ Yes No
If yes, please specify. _____
8. Has the patient ever had abnormal bleeding associated with previous extractions, surgery or trauma? _____ Yes No
9. Has the patient ever required a blood transfusion? _____ Yes No
If so, explain circumstances _____
10. Has the patient had surgery or x-ray treatment for a tumor, growth or condition of the mouth, lips? _____ Yes No
11. Is the patient employed in any situation which they are exposed regularly to x-rays? _____ Yes No
12. Female: Are you pregnant? _____ Yes No
13. Girls: Has menstruation started? _____ Yes No
Approx. date _____
14. Boys: Has voice changed or any facial hair growth? _____ Yes No

DENTAL QUESTIONNAIRE

DATE _____

NAME _____

1. Please tell us why you think you need to see an orthodontist. _____

2. Has the patient ever experienced any of the following:

A. Trouble associated with previous dental treatment _____ Yes No

B. Dental discomfort at this time _____ Yes No

C. Current gum bleeding _____ Yes No

D. Tooth sensitivity to cold, hot, sweets or chewing _____ Yes No

E. Jaw clicking _____ Yes No

F. Pain in or around the ears _____ Yes No

G. Frequent sores in and around the mouth _____ Yes No

H. Fear of dentistry _____ Yes No

I. Had periodontal (gum) treatment _____ Yes No

J. Had orthodontic treatment before _____ Yes No

K. Thumb or finger sucking habits? _____ Yes No

Please specify _____

3. Does the patient breathe through their mouth primarily? _____ Yes No

4. Does the patient grind or clench their teeth? _____ Yes No

5. Has the patient ever been told that they have a tongue thrust or reverse swallowing pattern? _____ Yes No

6. Have the patient's tonsils and or adenoids been removed? _____ Yes No

If yes, please indicate which. _____

7. Is there any hereditary background, which may contribute to this orthodontic problem?

Please specify. _____

8. Hobbies or special interests? _____

DATE **MEDICAL AND DENTAL NOTES (FOR DOCTOR'S USE)**

DOCTOR'S SIGNATURE

ORTHODONTIC EVALUATION

	TEETH PRESENT			
	ALIGNMENT	PROFILE		
	TRANSVERSE	SAGITTAL		
	VERTICAL			
	SEVERITY:	MARKED	MODERATE	MINIMUM
	THER. MOD:	GOOD	FAIR	POOR
	MOTIVE, HYGIENE:	GOOD	FAIR	POOR

REMARKS: