ND ORTHODONTICS

CONFIDENTIAL: Child/Adolescent

Patient Information

Date:________________

Patient's name:____
Last First Middle

Address:____
Street City State Zip

Social Security #:_____________________ Age:___ Sex:___ Height:________ Weight:________ Birthdate:________________

School:_____________________________ Grade:________________ Sports/Hobbies:____________________________

Father's Name:____Marital Status:________________

Address:____
Street City State Zip

Previous Address (if less than 3 years): ____
Street City State Zip

Home #:____________________ Work #:_______________ Cell #:_________________ Email:____________________________

Social Security #:____ Employer:____________________________

Occupation:____ # of Years Employed:____________________________

Mother's Name:____Marital Status:________________

Address:____
Street City State Zip

Previous Address (if less than 3 years): ____
Street City State Zip

Home #:____________________ Work #:_______________ Cell #:_________________ Email:____________________________

Social Security #:____ Employer:____________________________

Occupation:____ # of Years Employed:____________________________

Person(s) assuming financial responsibility:____

Name and ages of children in family:____

Other family members treated here?____

Who suggested that you might need orthodontic treatment?____

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

Insurance Information

Primary Insurance Information

Insured's Name:____________________________________Insured's Social Security #:____________________________

Insurance Company:_________________________Group #:_______________ Subscriber #:____________________________

Insurance Co. Address:______________________________________Phone:____________________________

Insured's Employer:_________________________Insured's DOB:____________________________

Relationship to Patient:____

Home #:____________________ Work #:_______________ Cell #:_________________ Email:____________________________

Secondary Insurance Information

Insured's Name:____________________________________Insured's Social Security #:____________________________

Insurance Company:_________________________Group #:_______________ Subscriber #:____________________________

Insurance Co. Address:______________________________________Phone:____________________________

Insured's Employer:_________________________Insured's DOB:____________________________

Relationship to Patient:____

Home #:____________________ Work #:_______________ Cell #:_________________ Email:____________________________

Emergency Information

Person to contact in case of emergency:____
Home #:____________________ Work #:____________________ Cell #: ____________________

Medical History

Medical Contact

Physician:______________________________ Phone:____________________________
Address:____
Street City State Zip

Medical History

Y N Are you in good health? Your last physical exam was_______________(month/year)
Y N Are you now under the care of a physician? If so, what is being treated?____________________
Y N Have you had a serious illness/hospitalization in the past 5 years? If so, explain:____________________
Y N Are you taking any medication? (if yes, please describe): ______________________________

Please indicate if you are allergic or have reacted adversely to:

Y N Latex
Y N Penicillin or other antibiotics
Y N Sulfa Drugs
Y N Aspirin, Ibuprofen, Tylenol
Y N Local Anesthetics
Y N Codeine or other narcotics
Y N Vinyl
Y N Acrylic
Y N Metals (jewelry, clothing snaps)
Y N Other______________________________

Girls Only:

Y N Have you started monthly periods?
If so, when?____________
Y N Are you pregnant?

Please indicate if you have experienced any of the following conditions:

Y	N	Low blood pressure	Y	N	Fainting spells or seizures
Y	N	High blood pressure	Y	N	Epilepsy or other neurological disorder
Y	N	Cardiovascular disease	Y	N	Blood disorder such as anemia
Y	N	Rheumatic fever	Y	N	Eye, ear, nose or throat condition
Y	N	Heart murmur	Y	N	Tire easily
Y	N	Arthritis or joint problems	Y	N	Problems of the immune system
Y	N	Respiratory problems, emphysema	Y	N	Birth Defects
Y	N	Asthma or hay fever	Y	N	Kidney trouble
Y	N	Sinus trouble	Y	N	Tuberculosis, polio, mononucleosis
Y	N	Persistent swollen neck gland	Y	N	Bone fractures or trauma to face or jaw
Y	N	Thyroid or endocrine problems	Y	N	Vision, hearing or speech difficulty
Y	N	Diabetes	Y	N	Persistent cough
Y	N	Hepatitis, jaundice or liver disease	Y	N	Frequent colds or sore throats
Y	N	AIDS or HIV infection	Y	N	Frequent headaches
Y	N	Sexually transmitted disease	Y	N	Stomach ulcer or hyperacidity
Y	N	Substance abuse problem (past or present)	Y	N	Tumor (cancerous or benign)
Y	N	Chew or smoke tobacco (past or present)	Y	N	Radiation therapy or chemotherapy
Y	N	Mental health problem or nervous disorder	Y	N	Tonsils/adenoids removed? What age:_____
Y	N	Abnormal bleeding or blood transfusion	Y	N	Loss of weight recently, poor appetite
Y	N	History of eating disorder (anorexia, bulimia)	Y	N	Skin disorder

Y N Do you have any disease, condition or problem not listed above that you think we should know about? If so, please explain:____

O R T H O D O N T I C S

Dental History

General Dentist:______________________________ Phone:______________________________

Address:____

Street City State Zip

Date of last dental exam:_______________Reason for last dental exam:______________________________

Reason for your consultation today:____

Y	N	Previous orthodontic exam, treatment, or retainer	Y	N	Teeth sensitive to hot or cold
Y	N	Mouth breathing habit or snoring troubles	Y	N	Loose or shifting teeth
Y	N	Abnormal swallowing (tongue thrust)	Y	N	Periodontal (gum) problems
Y	N	Frequent canker sores or cold sores	Y	N	Bleeding gums or bad mouth odor
Y	N	Thumb or finger habit as a child? Age______	Y	N	Jaw fracture/cyst/mouth infections
Y	N	Would you wear orthodontic appliances (braces) if indicated?	Y	N	Anxiety about dental visits?
Y	N	Problems with food trapped between teeth			

TMJ History

Y	N	Have you had a TMJ screening?	Y	N	Do you have pain in your jaw joint?
Y	N	Do you have a history of jaw joint problems?	Y	N	Do you grind your teeth?
Y	N	Do you clench your teeth?	Y	N	Have you been treated for “TMJ”?
Y	N	Soreness in facial muscles or around ears?	Y	N	Has your jaw ever locked?
Y	N	Does your bite feel uncomfortable?	Y	N	Have you noticed clicking or popping?
Y	N	Do you have difficulty chewing or opening your mouth?			

Patient Motivation For Orthodontic Treatment

Patients and their general dentists often request changes in bites and relief from pain or discomfort. Please help us to understand your concerns by checking the following information; please be specific (circle the words more, less, forward, etc.)

Teeth – If your teeth could be changed, how would you like them to change?

- ☐ Straighten the front teeth – **upper / lower**
- ☐ Straighten the back teeth – **upper/lower**
- ☐ Move upper teeth – **forward / backward**
- ☐ Move lower teeth – **forward / backward**
- ☐ Eliminate crowding of teeth – **upper / lower**
- ☐ Eliminate spaces between teeth – **upper / lower**
- ☐ Make the line of upper teeth more level
- ☐ Other_______________________________________

Face – If your facial appearance could be changed, what would you change?

- ☐ Move upper lip – **forward / backward**
- ☐ Move lower lip – **forward / backward**
- ☐ Show – **more / less** – of teeth when smiling
- ☐ Show – **more / less** – of gums when smiling
- ☐ Reduce the strain in – **chin / lips** – when lips close
- ☐ Make lips – **closer together / farther apart** – when teeth are touching
- ☐ Make profile of nose – **longer / shorter**
- ☐ Get rid of sag under lower jaw
- ☐ Move chin – **forward / backward**
- ☐ Move chin – **left / right**
- ☐ Other_______________________________

I hereby acknowledge that I have read and understood the above questions and that the information that I provided is accurate to the best of my knowledge. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I further consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes. If there are any changes later to this history record or medical/dental status, I will so inform this practice. I understand that where appropriate, credit bureau reports may be obtained.

____
Signature of Patient Date

______________________________ ______________________________
Update Signature Date Update Signature Date

______________________________ ______________________________
Update Signature Date Update Signature Date

____
Staff Signature Date