

Child Information

Child's Name: _____
 Child's Preferred Name: _____ Sex: _____
 Birth Date: _____
 School: _____ Grade: _____
 Sport/Hobbies: _____
 Play musical instruments: Yes ___ No ___
 Siblings Name /Age: _____

 How did you hear about our office: _____

Dental Information

Dentist Referral: Yes ___ No ___
 Dentist Name: _____
 Last Visit Date: _____
 Have any teeth been extracted: Yes ___ No ___
 Oral habits finger/thumb sucking: Yes ___ No ___
 Any trauma injuries to the face/teeth: Yes ___ No ___
 Any chipped or fractured teeth: Yes ___ No ___
 Any sensitive/painful teeth: Yes ___ No ___
 Mouth breathing/snoring: Yes ___ No ___
 Bleeding gums: Yes ___ No ___
 Root canals: Yes ___ No ___
 Extra or missing teeth: Yes ___ No ___
 Pain or soreness around jaws or ears: Yes ___ No ___
 Tonsils removed: Yes ___ No ___
 Speech problems: Yes ___ No ___
 Grind teeth: Yes ___ No ___
 Previous orthodontic treatment: Yes ___ No ___
 Previous orthodontic evaluations: Yes ___ No ___
 Where: _____ When: _____

General Information

(Please circle)

Patient's attitude toward braces
 Wants braces Indifferent to braces Objects to braces
Dental History Experience
 Good Average Poor/fearful
Patient brushing history
 Once a day Twice a day Other _____
Patient flossing history
 Once a day Twice a day Other _____

Responsible Party

Mother ___ Father ___ Grandparent ___ Other ___
 Name: Mr. Mrs. Ms _____
 Address: _____

 Billing address if different: _____

 Employer: _____ How long: _____
 Position: _____
 Work #: _____ Cell # _____
 Email: _____

Additional Parent Information

Mother ___ Father ___ Grandparent ___ Other ___
 Name: Mr. Mrs. MS _____
 Address: _____

 Employer: _____
 How long: _____
 Position: _____
 Work #: _____ Cell # _____
 Email: _____

Orthodontic Insurance Information

Insurance Company Name _____
 Insurance Company Phone: _____
 Employer: _____
 Insured's Name: _____
 Insured's Social: _____
 Insured's Date of Birth: _____
 Company Group #: _____

Medical History

Physician: _____ Phone: _____

Last physical exam: _____

Tuberculosis/Lung Disease: Yes __ No __

Heart Problems: Yes __ No __

Congenital Heart defects: Yes __ No __

Heart murmur: Yes __ No __

Liver disease: Yes __ No __

Kidney disease: Yes __ No __

Diabetes: Yes __ No __

Pneumonia: Yes __ No __

Hemophilia: Yes __ No __

Endocrine disorder/growth problems: Yes __ No __

Hypertension/High Blood Pressure: Yes __ No __

Rheumatoid arthritis: Yes __ No __

Neurologic problems/epilepsy: Yes __ No __

Mental problems/epilepsy: Yes __ No __

Prolonged Bleeding/Transfusion: Yes __ No __

Anemia: Yes __ No __

HIV/AIDS: Yes __ No __

Birth defect or hereditary problems: Yes __ No __

Bone fractures: Yes __ No __

Skin disorder: Yes __ No __

Frequent infections/tonsillitis: Yes __ No __

Learning disorders: Yes __ No __

Hay fever/asthma: Yes __ No __

Eating disorders: Yes __ No __

Any family medical condition we should be aware of Yes __ No __

If so please explain: _____

Allergies or reactions to any of the following

Local anesthetics (Novocaine or Lidocaine): Yes__ No__

Aspirin: Yes__ No__

Ibuprofen (Motrin, Nuprin, Advil): Yes__ No__

Penicillin or other antibiotics: Yes__ No__

Sulfa drugs: Yes__ No__

Codeine or other narcotics: Yes__ No__

Metals (jewelry, clothing snaps): Yes__ No__

Latex (gloves, balloons): Yes__ No__

Vinyl: Yes__ No__

Acrylic: Yes__ No__

Foods (specify): _____

Animals: Yes__ No__

Are you or have you ever taken intravenous Bisposphonates for serious bone disorders/cancers, such as Zometa, Aredia, Didronel? Yes__ No__

Are you, or have you ever taken oral Bispophonates for osteoporosis, such as Fosama, Actonel, Boniva, Skelid, Didronel? Please list medications and length of time taking them.

Listed: _____ Length of time: _____

Listed: _____ Length of time: _____

Listed: _____ Length of time: _____

Listed: _____ Length of time: _____

General Information

Has puberty begun? Yes__ No__

If female, is the patient pregnant? Yes__ No__

Has patient grown in the past year? Yes__ No__

Has either biological parent ever had orthodontics? Yes__ No__

What is your primary concern with your teeth? _____

I have read and understand the above questions and the Hipa Privacy Act. 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. If there are any changes later to this history record or medical/dental status, I will inform this practice.

Signed: _____ Date Signed: _____

(Parent or Guardian if patient is a minor)

Signed: _____ Date Signed: _____

(Dental staff member)