



Welcome!

PATIENT NAME: _____ Nickname _____

AGE _____ DATE OF BIRTH _____ SCHOOL _____ GRADE _____

PATIENT'S ADDRESS _____ HOME PHONE _____

*EMAIL ADDRESS FOR APPOINTMENT CONFIRMATION: _____

FATHER'S NAME _____ **SS#** _____

ADDRESS (if different than above) _____

DAY PHONE _____ EMPLOYER _____ OCCUPATION _____

MOTHER'S NAME _____ **SS#** _____

ADDRESS (if different than above) _____

DAY PHONE _____ EMPLOYER _____ OCCUPATION _____

PATIENT'S DENTIST _____ **DATE OF LAST DENTAL EXAM** _____

PATIENT'S PHYSICIAN _____ **IS PATIENT IN GOOD HEALTH?** YES NO

If no, please explain _____

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESSES OR HOSPITALIZATIONS? YES NO

HAS THE PATIENT BEEN UNDER THE PROLONGED CARE OF A PHYSICIAN? YES NO

If Yes, please explain _____

HAS THERE BEEN ANY RECENT ILLNESS? _____

DOES THE PATIENT WEAR CONTACT LENSES? YES NO

CHECK THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Kidney Involvement | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Trouble/Chest Pain | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Fainting/Dizziness |

(CONTINUED ON BACK)

DOES THE PATIENT NEED TO BE PRE-MEDICATED PRIOR TO ANY DENTAL PROCEDURES? YES NO

Reason for Pre-Medication _____

PLEASE LIST ANY ALLERGIES OR DRUG SENSITIVITY: Penicillin____ Codeine____ Other_____

DOES PATIENT HAVE TENDENCY TO: Colds Sore Throats Ear Infections Canker Sores

HAVE TONSILS AND ADENOIDS BEEN REMOVED?_____ WHAT AGE?_____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN AND GIVE REASON

HAS PATIENT REACHED PUBERTY?..... HEIGHT_____ WEIGHT_____

GIRLS – Has she started menstruation? Yes No

IS THE PATIENT NOW EXPERIENCEING A RAPID GROWTH “SPURT”? Yes No

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? Yes No

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE?_____ ... Yes No

DOES THE PATIENT HAE ANY SPEECH PROBLEMS? Yes No

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? Yes No WHILE ASLEEP? Yes No

DOES THE PATIENT HAVE A NOSE OBSTRUCTION OR EXPERIENCE DIFFICULTY BREATHING THROUGH THE NOSE? Yes No

HAVE YOU EVER BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH?..... Yes No

HAS EITHER PARENT OR OTHER CHILDREN HAD ORTHODONTIC TREATMENT?..... Yes No

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? Yes No

IF YES, PLEASE PROVIDE NAME: _____

Other members of your family who have had Orthodontic Treatment: _____

Referred to this office by: _____

Reason for Consultation: _____

Parent’s Signature _____ Date _____