Welcome

Orthodontic New Patient Information

The following information is requested to enable me to give your child the best consideration of his/her orthodontic problem during the initial examination. For me to thoroughly diagnose any condition, I must have accurate background and health information on which to base my decisions. This information, which is important for my records, is confidential. Thank you.

Patient Name: _____ Age_____ DOB_____/_____/_____ ☐ Male ☐ Female
Home Address _____ Patient's Social Security #_____

Person Responsible for Account _____ Responsible Party's Email address _____

☐ Mother's information ☐ Step-mother ☐ Legal Guardian ☐ Grandmother ☐ Responsible for account

Name:	DOB:	Social Security #:
Address :	Home phone:	Cell phone:
Employer :	Occupation:	Work phone:

☐ Father's information ☐ Step-father ☐ Legal Guardian ☐ Grandmother ☐ Responsible for account

Name:	DOB:	Social Security #:
Address :	Home phone:	Cell phone:
Employer :	Occupation:	Work phone:

Physician_____ Dentist_____ Referred By_____
School_____ Grade_____ E-Mail Address_____

Dental Insurance Information

Ins. Co. Name _____ Phone _____
Employer: _____ Group # _____ Policy #_____
Who is the primary person on this policy? _____ SS# _____

Names and ages of other children in the family _____

Emergency Information

Name of Nearest Relative Not Living With You_____ Relationship to Patient _____
Address _____Telephone _____

Medical History (Please check all that apply)

☐ Attention Deficit Disorder ☐ Epilepsy ☐ Hepatitis ☐ Nasal/Sinus Problems
☐ Asthma ☐ Growth Problems ☐ HIV Positive ☐ Rheumatic Fever
☐ Blood Disorders ☐ Hearing Disorder ☐ Kidney Disease ☐ Speech Disorder
☐ Diabetes ☐ Heart Disease ☐ Mononucleosis ☐ Tuberculosis
☐ Other (Describe Below)

Comments_____
_____

Is antibiotic medication necessary before dental appointments due to a heart condition? _____ ☐ Yes ☐ No
Has the patient been under the care of a physician during the past two years, other than for routine examinations? _____ ☐ Yes ☐ No
If yes why? _____
Present drugs or medications_____
Has the patient experienced a sudden increase in height? _____ ☐ Yes ☐ No

Respiratory History

Does the patient:

1. Have allergies to: Seasonal grasses ☐ Yes ☐ No Foods ☐ Yes ☐ No Metals ☐ Yes ☐ No Latex ☐ Yes ☐ No
   Drugs ☐ Yes ☐ No Other:_____
   If yes, please specify: _____
2. Breathe through mouth regularly? _____ ☐ Usually ☐ Sometimes ☐ Seldom
3. Snore when sleeping? _____ ☐ Yes ☐ No
4. Has the patient received medical treatment from an allergist or ear, nose, and throat specialist? _____ ☐ Yes ☐ No
   If Yes, When? _____ By Whom? _____For What?_____
5. Have chewing or swallowing difficulty? _____ ☐ Yes ☐ No

Dental History

Does patient visit his/her dentist regularly (twice a year)? __ _____ ☐ Yes ☐ No
Last visit to the dentist? _____Teeth cleaned?_____ ☐ Yes ☐ No
Has he/she gone through a preventive program with his/her dentist? _____ ☐ Yes ☐ No
Daily tooth brushing frequency? ☐ 1 ☐ 2 ☐ 3 Floss Daily? _____ ☐ Yes ☐ No
Facial or dental injury due to accidents or blows to the mouth? _____ ☐ Yes ☐ No
If yes, Explain: _____
Congenitally missing, extra, or impacted teeth? _____ ☐ Yes ☐ No
Has the patient had any teeth extracted due to decay or gum disease?_____ ☐ Yes ☐ No
Has the patient ever been treated by a periodontist (Gum Specialist) ? _____ ☐ Yes ☐ No
If yes, by whom? _____ When? _____
The following habits are of interest. List information as it pertains to patient:
Thumb sucking until age _____Grinding/ Clenching of teeth_____ ☐ Yes ☐ No
Finger sucking until age _____Tongue Thrusting_____ ☐ Yes ☐ No
Lip biting or sucking_____ ☐ Yes ☐ No Other Habits_____ ☐ Yes ☐ No
Does patient have frequent headaches?_____ ☐ Yes ☐ No
How often ?_____ In the morning? ☐ Yes ☐ No In the Evening? ☐ Yes ☐ No
Location of headaches? _____
Has patient ever experienced pain, clicking, or popping in his/her joints?_____ ☐ Yes ☐ No
Pain ☐ Right ☐ Left Clicking ☐ Right ☐ Left Popping ☐ Right ☐ Left Earaches ☐ Right ☐ Left
Has his/her jaw ever locked open ? _____ ☐ Yes ☐ No Locked closed?_____ ☐ Yes ☐ No
Has the patient ever been treated for temporomandibular joint (TMJ) problems? _____ ☐ Yes ☐ No
If yes, by whom? _____ When? _____
Has an orthodontist been consulted previously? _____ ☐ Yes ☐ No
Has the patient had orthodontic treatment previously? _____ ☐ Yes ☐ No
If yes, by whom? _____ When? _____
Has anyone in your family had orthodontic treatment? _____ ☐ Yes ☐ No
Has there been any apprehension or unfavorable experience in a dental office? _____ ☐ Yes ☐ No
How does the patient feel about braces? _____ ☐ Excited ☐ Tolerable ☐ Resentful
Is there a family history of similar orthodontic problems? _____ ☐ Yes ☐ No
If yes, please describe_____
Does the patient play a musical instrument with his/her mouth? _____ ☐ Yes ☐ No
What level of cooperation can we expect from the patient? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
What is primary reason for seeking this orthodontic evaluation? _____
What concerns do have about braces, orthodontic treatment, etc. ? _____
_____
Are parents aware that some orthodontic appointments will infringe on school time? _____ ☐ Yes ☐ No

Please Read, Sign, and Date: I, the undersigned, verify the accuracy of the above information. If there are any changes in the future, I will inform this practice of these changes. I authorize the dental staff to perform the necessary orthodontic services my child may need.

_____ _____

Signature of Patient/Responsible Party **Date**

Privacy Policy Acknowledgement Statement

I have been told that Children's Dentistry and Orthodontics has a privacy policy in place according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient of Children's Dentistry and Orthodontics, I acknowledge Children's Dentistry and Orthodontics has made this policy available to me. _____**Initial**

Office Use Only

I have verbally reviewed the medical/dental information with parent/guardian and patient herein

Comments: _____

Orthodontist: _____ Date: _____