



CHILD

## Getting to Know You:

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ LIKES TO BE CALLED \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Is patient adopted? \_\_\_\_\_

Address \_\_\_\_\_ City & Zip \_\_\_\_\_ Phone \_\_\_\_\_

Patient's School \_\_\_\_\_

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Person Responsible for account \_\_\_\_\_

Father/Mother address if different from patient \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Do you anticipate a move or transfer in the next 6-12 months? . . . . . Yes No

Does patient have orthodontic insurance? . . . . . Yes No

## DENTAL HISTORY

Patient's dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

PLEASE CIRCLE YES OR NO

Have you had the following treatment?	Are you aware of any of the following problems?
Previous orthodontic exam or treatment: . . . Yes No	Clicking, popping or grating noise in your jaw joints? . . . Yes No
Extractions (teeth removed)? . . . . . Yes No	If yes, does it bother you? . . . . . Yes No
Periodontal (gum) treatment? . . . . . Yes No	Clenching or grinding of your teeth? . . . . . Yes No
Endodontic (root canal) therapy? . . . . . Yes No	Frequent toothaches or sensitive teeth? . . . . . Yes No
TMJ (jaw joint) problems or therapy? . . . . . Yes No	Food catching or collecting between your teeth? . . . . . Yes No
Mouthguard/splint (plastic device	Sores, lumps or irritated areas in your mouth? . . . . . Yes No
between teeth), surgery or chiropractic? . Yes No	Numbness or pain in your mouth, jaw joints or face? . . . Yes No
History of mouth breathing, finger or thumb sucking, nail biting? . . . . . Yes No	
History of injury to face, head or teeth? . . . . . Yes No	
Have tonsils and adenoids been removed? _____ Date _____	
Has patient reached puberty (girls-menstruation; boys-voice change)? . . . . . Yes No	
Would patient mind wearing "braces" if necessary? . . . . . Yes No	

Describe the orthodontic problem in your own words (what are YOUR main concerns?) \_\_\_\_\_

Who noticed the problem? Patient \_\_\_\_\_ Parent \_\_\_\_\_ Dentist \_\_\_\_\_

Any comments, questions, or suggestions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Medical History

Patient's physician(s) \_\_\_\_\_ Date last seen \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

1. Please circle you PRESENT HEALTH:    excellent    good    fair    poor
  2. Has your health CHANGED in the last year? . . . . . Yes No
  3. Have you been HOSPITALIZED in the last 5 years? . . . . . Yes No
  4. Has a doctor TREATED or EXAMINED you for any condition in the last 3 years? . . . . . Yes No
  5. Are you ALLERGIC to any drugs or other substances? . . . . . Yes No
  6. Are you required to restrict your work or activities? . . . . . Yes No
  7. Is your diet restricted or specially prescribed? . . . . . Yes No
  8. Are you taking ANY MEDICATIONS regularly (even aspirin or antacids)? . . . . . Yes No
- If "Yes" , please list them with dosages: \_\_\_\_\_

PLEASE CIRCLE YES OR NO FOR ANY CONDITION EVEN IF YOU NO LONGER HAVE THEM.

- |   |   |   |
|---|---|---|
| 1. Heart trouble or murmur . . . . . Yes No             | 17. Bronchitis . . . . . Yes No                     | 34. Sinus trouble . . . . . Yes No                          |
| 2. Rheumatic fever . . . . . Yes No                     | 18. Frequent colds/<br>sore throat . . . . . Yes No | 35. Artificial joints or valves . . . . . Yes No            |
| 3. Heart surgery . . . . . Yes No                       | 19. Emphysema . . . . . Yes No                      | 36. Venereal disease . . . . . Yes No                       |
| 4. Heart attack . . . . . Yes No                        | 20. Birth Defects . . . . . Yes No                  | 37. Thyroid/parathyroid<br>disorders . . . . . Yes No       |
| 5. High blood pressure . . . . . Yes No                 | 21. Scarlet fever . . . . . Yes No                  | 38. Cancer or tumors . . . . . Yes No                       |
| 6. Low blood pressure . . . . . Yes No                  | 22. Hives/rash . . . . . Yes No                     | 39. Tuberculosis . . . . . Yes No                           |
| 7. Chest pains . . . . . Yes No                         | 23. Recurrent illness . . . . . Yes No              | 40. Speech impairment or<br>therapy . . . . . Yes No        |
| 8. Stroke . . . . . Yes No                              | 24. Diabetes . . . . . Yes No                       | 41. Hearing problem . . . . . Yes No                        |
| 9. Immune system<br>problems, AIDS . . . . . Yes No     | 25. Kidney disease . . . . . Yes No                 | 42. Emotional or<br>nervous problems . . . . . Yes No       |
| 10. Blood transfusion . . . . . Yes No                  | 26. Liver disease . . . . . Yes No                  | 43. Frequent headaches . . . . . Yes No                     |
| 11. Excessive or<br>prolonged bleeding . . . . . Yes No | 27. Epilepsy/seizures . . . . . Yes No              | 44. Smoker . . . . . Yes No                                 |
| 12. Blood disorder . . . . . Yes No                     | 28. Fainting/dizzy spells . . . . . Yes No          | 45. Nervous/anxious . . . . . Yes No                        |
| 13. Shortness of breath . . . . . Yes No                | 29. Ulcers . . . . . Yes No                         | 46. Recent unintentional<br>weight changes . . . . . Yes No |
| 14. Persistent cough . . . . . Yes No                   | 30. Arthritis . . . . . Yes No                      | 47. Psychiatric care . . . . . Yes No                       |
| 15. Asthma/hay fever . . . . . Yes No                   | 31. Glaucoma . . . . . Yes No                       |   |
| 16. Lung disease . . . . . Yes No                       | 32. Allergies . . . . . Yes No                      |   |
|   | 33. Ear pains or infections . . . . . Yes No        |   |

IF FEMALE, ARE YOU:

Pregnant/Nursing . . . . . Yes No    On Birth Control Pills . . . . . Yes No

IS THERE ANY CONDITION OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT?

COMMENTS: \_\_\_\_\_

1. \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent or Guardian

2. \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent or Guardian

3. \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent or Guardian

4. \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent or Guardian

5. \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent or Guardian

6. \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent or Guardian