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UNDER 18 PATIENT INFORMATION FORM

Welcome to our office, your answers to the following questions will be helpful in selecting the safest and most effective means of providing orthodontic treatment.

PLEASE MAKE SURE TO COMPLETE BOTH SIDES OF THIS FORM. ALL INFORMATION WILL BE KEPT COMPLETELY CONFIDENTIAL.

Date: _____ Whom may we thank for your referral?: _____

PATIENT INFORMATION

Last Name First Middle Preferred Name

Address City State/Zip

Home Phone Date of Birth Age Sex S.S.N

Employed By Work Phone Other

Business Address Occupation

Favorite Sports, Hobbies & Avocations

Brothers/Sisters (Yes / No) Name(s)

School Attending Grade Musical Instrument(s) Played

RESPONSIBLE PARTY INFORMATION

Name Of Person Responsible For Account Relationship To Patient

Father's Name Address (if different from above) S.S.N

Employed By Work Phone D.O.B

Mother's Name Address (if different from above) S.S.N

Employed By Work Phone D.O.B

Do You Have Dental Insurance? ☐ Yes ☐ No (If yes, please provide a copy of insurance card)

In case we cannot reach you, person(s) to contact Phone Number

MEDICAL HISTORY

Physician's Name Phone Number

Address City State/Zip

			Explain all YES answers
Is the patient in good health?	Y	N	
Does the patient have a history of a major illness?	Y	N	
Is the patient presently under the care of a physician?	Y	N	
Is the patient taking any medications?	Y	N	
Is the patient allergic to: ☐ penicillin ☐ codeine ☐ local anesthetics ☐ banthine			
Is the patient allergic or sensitive to any other drugs, foods, metals or other products (i.e. latex, nickel?	Y	N	
Has the patient had surgery that involves the placement of prosthesis (i.e. hip/knee replacement, heart valve, etc.)?	Y	N	
Has the patient had surgery or radiation treatment for a tumor or growth in the head and neck area?	Y	N	

(Boys) Has voice changed? ☐ Yes ☐ No **(Girls)** Has menstruation begun? ☐ Yes ☐ No Onset of puberty (approx date)_____

Patient's Height _____ Patient's Weight_____ Mother's Height _____Father's Height _____

Please check if you have any of the following conditions:

- ☐ HIV Positive/AIDS
- ☐ Hepatitis Type____
- ☐ Liver Disease/Jaundice
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Scarlet Fever
- ☐ Heart Murmur
- ☐ Heart Trouble/Surgery
- ☐ Heart Valve Defects
- ☐ Tuberculosis
- ☐ High/Low BP
- ☐ Diabetes
- ☐ Bleeding Problems
- ☐ Lung Disease
- ☐ Epilepsy/Seizures
- ☐ Arthritis
- ☐ Lupus/CT Disease
- ☐ Kidney Disease
- ☐ Allergies
- ☐ Asthma/Lung Disease
- ☐ Cancer
- ☐ Anemia
- ☐ Glaucoma
- ☐ Degenerative Joints
- ☐ Thyroid Problems
- ☐ Veneral Disease
- ☐ Rheumatoid Arthritis
- ☐ Stomach Ulcers
- ☐ Gastric Reflux
- ☐ Polio
- ☐ Monoucleosis
- ☐ Substance Abuse
- ☐ Migraine Headaches
- ☐ Emotional Problems
- ☐ Stroke
- ☐ Frequent Headaches
- ☐ Endocrine Problems
- ☐ Nervous Disorders
- ☐ Bone Disorders
- ☐ Facial Pain
- ☐ Bulimia
- ☐ Anorexia Nervosa
- ☐ Muscular Disorder
- ☐ Fainting Spells
- ☐ Other_____

Comments: _____

_____

DENTAL HISTORY

_____

Physician's Name Phone Number

_____

Address City State/Zip

Please check any of the following conditions: for which you have been diagnosed or treated:

- ☐ Facial/Teeth/Jaw Injury
- ☐ THJ/TMD/Jaw Problems
- ☐ Grinding/Clenching Habit
- ☐ Jaw Clicking/Popping
- ☐ Jaw Locking
- ☐ Tongue Thrust
- ☐ Bleeding Gums
- ☐ Receding
- ☐ Gum Disease
- ☐ Lip Habit
- ☐ Dead Teeth/Root Canal
- ☐ Tooth Sensitivity
- ☐ Chipped or Broken Teeth
- ☐ Thumb or Finger Habit
- ☐ Facial Pain
- ☐ Ringing In The Ear
- ☐ Cold Sores
- ☐ Mouth Ulcers
- ☐ Jaw Cysts/Tumors
- ☐ Missing Teeth
- ☐ Mouth Breathing
- ☐ Impacted Teeth
- ☐ Receding Jaw
- ☐ Other_____
- ☐ Other_____

Comments: _____

_____

Which of the following are significant concerns?

- ☐ Crooked/Crowded Teeth
- ☐ Impacted Teeth
- ☐ Spaced Teeth
- ☐ Under Developed Jaw
- ☐ Over Developed Jaw
- ☐ Tooth Wear
- ☐ Extra Teeth
- ☐ Wisdom Teeth
- ☐ Missing Teeth
- ☐ Protruding Teeth
- ☐ Overbite
- ☐ Other_____

Comments: _____

_____

What would you change about your teeth or smile?_____

Have you had a prior orthodontic exam or prior orthodontic treatment?	Y	N
Are you currently under a general dentist's care?	Y	N
When was your last dental exam and cleaning?		

Realizing the successful treatment greatly depends upon the patient's complete cooperation in following instruction, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?
If so, please explain _____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for anyy 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 so inform this practice.

_____ _____

Signature of Patient or Guardian of Patient Date

CONSENT FOR DIAGNOSTIC RECORDS

I consent to the taking of x-rays, models and photographs necessary for diagnostic purposes.

_____ _____

Signature of Patient or Guardian of Patient Date