Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

PATIENT INFORMATION

Date:_____ 20 ____

Patients Name _____
First Name Middle Initial Last Name

Patient would like to be addressed as _____ Hobbies _____

Gender ☐ M ☐ F Age____ Birthdate____-____-____ Grade_____ School_____

Home Address: _____
Street City Zip

Home Phone ( ) _____ Patient lives with: Mother & Father Mother Father Other _____
(Circle One)

Names and ages of other children in family_____

Whom may we thank for referring you to our office?_____ Patient's Dentist _____

FINANCIAL INFORMATION **Credit bureau reports may be obtained when appropriate.**

Father's/Guardian's Name _____

Address (if different from patient's) _____

_____

E-mail _____

Home Phone ( ) _____

Work Phone ( ) _____

Cell Phone ( ) _____

Employer_____

Occupation _____ # years employed ____

Soc. Sec. #____-____-____ Birthdate ___-___-___

Do you have orthodontic insurance coverage for minor/child? ☐ Yes ☐ No

Insurance Company _____

Phone No. ( ) _____ Group #_____

Address_____

Mother's/Guardian Name _____

Address (if different from patient's)_____

_____

E-mail _____

Home Phone ( ) _____

Work Phone ( ) _____

Cell Phone ( ) _____

Employer_____

Occupation _____ # years employed ____

Soc. Sec. # ____-____-____ Birthdate ___-___-___

Do you have orthodontic insurance coverage for minor/child? ☐ Yes ☐ No

Insurance Company _____

Phone No. ( ) _____ Group # _____

Address_____

MEDICAL HISTORY

Is patient in good health? ☐ Yes ☐ No Has the patient ever been under the care of a physician for illness? ☐ Yes ☐ No

Check any of the following for which the patient has been treated:

Diabetes ☐ AIDS ☐ Bone Disorders ☐ Nervous Disorders ☐ Pneumonia ☐ Anemia ☐ Tuberculosis ☐ Liver Involvement ☐

Heart Trouble ☐ Epilepsy ☐ Prolonged Bleeding ☐ Endocrine Problems ☐ Rheumatic Fever ☐ Asthma ☐ Kidney Involvement ☐ Fainting or Dizziness ☐

Other _____

Does patient have tendency to colds? ☐ Yes ☐ No Sore throats? ☐ Yes ☐ No Ear infections? ☐ Yes ☐ No

Have tonsils and adenoids been removed? ☐ Yes ☐ No At what age? _____

List any drugs or medications now being taken. Give reasons: _____

_____

List any allergies or drug sensitivity:_____

Has the patient reached puberty? ☐ GIRLS: Has she started menstruation? ☐ Yes ☐ No If yes, when?_____

☐ BOYS: Has his voice changed? ☐ Yes ☐ No

Child's Height _____ Father's Height _____ Mother's Height _____

PLEASE COMPLETE BOTH SIDES

Name_____ Age _____ Gender_____ Model Number_____

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? ..... ❑ Yes ❑ No

Has the patient ever sucked a thumb or fingers? ..... ❑ Yes ❑ No Until what age?_____

Does the patient have any speech problems? ..... ❑ Yes ❑ No

Is the patient a mouth breather? ❑ Yes ❑ No While awake ❑ Yes ❑ No While asleep ❑ Yes ❑ No

Have you been informed of any missing or extra permanent teeth? ..... ❑ Yes ❑ No

Has an orthodontist been consulted previously? ..... ❑ Yes ❑ No

Has either parent had orthodontic treatment? ..... ❑ Yes ❑ No

List any musical instruments played and hobbies _____

Reason for consultation _____

X _____

Signature (parent or guardian, if patient is a minor)

DO NOT WRITE BELOW THIS LINE

Skeletal _____

Dental - Molar Rt _____ Lt _____

Cuspid Rt _____ Lt _____

Overbite _____

Overjet _____

Missing or Impacted Teeth _____

Crossbite _____

Arch Length - Upper _____ mm ❑ Crowding ❑ Spacing

Lower _____ mm ❑ Crowding ❑ Spacing

Tooth Size Discrepancy _____

Median Line _____

Profile _____

Lip Posture _____

Eruption Pattern _____

Habits _____

Frenum _____

Periodontal _____

T.M.J. - Max. Open _____ mm

Lateral Rt _____ mm Lt _____ mm

Click Rt _____ Lt _____

Pain Rt _____ Lt _____

Excess Mobility - Rt _____ Lt _____

Locking Rt _____ Lt _____

Other _____

Teeth Present:

Right																Left
				E	D	C	B	A	A	B	C	D	E			
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
				E	D	C	B	A	A	B	C	D	E			

Misc. _____

Probable Treatment _____

Est. Tx. Time _____

Est. Fee _____

Who Present: M F SM SF GM GF A U Gu

DATE		FEE

DATE		FEE