Patient Information

Date____________________ Home Phone ____________________ Birthdate____________________

Patient's Name____________________
last first middle nickname

Address____________________
street city state zip

Height __________ Weight__________ Sex__________ School____________________ Grade__________

Patient's Concerns____________________ Parent/Guardian's Concerns____________________

Whom may we thank for referring you to our office?____________________

Any friends or family members in our practice?____________________

Names and ages of siblings____________________

What are your hobbies or interests?____________________

Patient's E-mail Address: ____________________

Parents/Responsible Party Information

Parent/Guardian #1 Name____________________ M S D__________
last first middle Marital Status

Parent/Guardian #1 Address____________________
street city state zip

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

E-mail Address: ____________________

SS# ____________________ Birthdate ____________________ Relationship to patient ____________________

Employer ____________________ Occupation ____________________ No. years employed __________

Parent/Guardian #2 Name____________________ M S D__________
last first middle Marital Status

Parent/Guardian #2 Address____________________
street city state zip

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

E-mail Address: ____________________

SS# ____________________ Birthdate ____________________ Relationship to patient ____________________

Employer ____________________ Occupation ____________________ No. years employed __________

Insurance Information

Subscriber's Name____________________ Birthdate__________ ID# ____________________

Insurance Company____________________ Group No. __________ Phone# ____________________

Insurance Co. Address____________________ Payor ID#____________________

Insured's Employer (name & address)____________________

Subscriber's #2 Name ____________________ Birthdate____________________ ID#____________________

Insurance Company____________________ Group No.____________________ Phone# ____________________

Insurance Co. Address____________________ Payor ID#____________________

Insured's Employer (name & address)____________________

Parent or Guardians Signature____________________

Updates (date & initial)__________ __________ __________ __________

Patient Medical History

General Health (please check): Excellent ________ Good ________ Fair ________ Poor ________

Name & Address of Physician: ________

Is Patient taking any medication now? NO _____ YES _____ Please list & give purpose: ________

____

Has patient been treated for any of the following?

Autism.. Yes_______ No _____

ADHD .... Yes_______ No _____

Abnormal Blood Pressure............... Yes_______ No _____

Ulcers .... Yes_______ No _____

Diabetes .... Yes_______ No _____

Arthritis .... Yes_______ No _____

Stroke .... Yes_______ No _____

Bleeding problems.......................... Yes_______ No _____

Bone disorders .... Yes_______ No _____

Fainting or dizziness....................... Yes_______ No _____

Nervous disorders/Epilepsy............ Yes_______ No _____

Behavioral Problem ________

Heart disease/Rheumatic fever .... Yes_______ No _____

Heart murmur .... Yes_______ No _____

Congenital heart lesions .... Yes_______ No _____

Asthma/Sinus/Hay fever .... Yes_______ No _____

AIDS .... Yes_______ No _____

Hepatitis/Jaundice .... Yes_______ No _____

Anemia .... Yes_______ No _____

Cancer .... Yes_______ No _____

Endocrine problems........................ Yes_______ No _____

Kidney involvement .... Yes_______ No _____

Tuberculosis/lung disease .... Yes_______ No _____

Other ________

Are you allergic to: Penicillin _______ Codeine _______ Latex _______ Local injected anesthetics _______

Any other medications? ________

Has patient reached puberty?

Girls: Has she started menstruation? .... Yes ______ No______

At what Age?.. ________

Boys: Has his voice changed?... Yes ______ No______

At What Age?... ________

Is patient pregnant?............................... Yes _________ No_________ How far along ________

Has patient ever taken any Bisphosphonates (i.e. Actonel, Boniva, Fosamax)? Yes _______ No_________

Dental History

Date of your last dental visit: ________ Reason for visit: ________

Name of Dentist________ Dentist's Concerns ________

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

Have you ever sucked your fingers or thumb? .... Yes _____ No _____

Any history of oral habits? Nail biting ________ , Pencil chewing ________ , Extended pacifier ________

Do you clench or grind your teeth while sleeping or during the day?.. Yes _____ No _____

Do you have any speech problems? .... Yes _____ No _____

Are you a mouth breather?................................Yes _______ No ______ While awake?__________While asleep? _______

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

Have you consulted an orthodontist previously?.. Yes _____ No _____

Did either parent have orthodontic treatment? .... Yes _____ No _____

Do you have pain in the jaw joints?.. Right _________Left _____ No _____

Do you have popping or cracking of the jaw joints? .... Right _________Left _____ No _____

When did this begin? ________

Do you have headaches? ________ How often? ________ Location ________

Do you chew on only one side of your mouth or both? ________

Do you chew gum?... Yes ______ No________ If yes, how often? ________

Have you ever smoked?... Yes ______ No________ Chewed tobacco? Yes_______ No ______