

Welcome!

Thank you for your visit today! We are pleased to welcome you and your child to our practice.
We look forward to working with you to maintain your child's dental health!

PATIENT INFORMATION

Date _____ Home Phone _____

Child's Name _____ Nickname _____

Sex Male ___ Female ___ Age ___ Date Of Birth _____

Address _____

Person Financially Responsible _____

How did you hear about our practice? _____

RESPONSIBLE PARTY & INSURANCE INFORMATION

Email address _____

Father's name _____

Address _____

Home ph. _____ Work _____

Cell _____

Employer _____

Employer address _____

City _____ Zip _____

SSN _____ DOB _____

Email address _____

Mother's name _____

Address _____

Home ph. _____ Work _____

Cell _____

Employer _____

Employer address _____

City _____ Zip _____

SSN _____ DOB _____

Dental Insurance Primary

Policy Holder _____

Insurance Company Name _____

Address _____

Phone _____

Policy# _____

Group# _____

Dental Insurance Secondary

Policy Holder _____

Insurance Company Name _____

Address _____

Phone _____

Policy# _____

Group# _____

Medical History

Now or in the past, has the patient had:

Heart problems Y__N__

If yes, please specify _____

Does patient require any medication for dental procedures due to a heart problem? Y__N__

If yes, please specify _____

Birth defects or hereditary problems Y__N__

Bone fractures or major accidents Y__N__

Rheumatoid or arthritic conditions Y__N__

Endocrine or thyroid problems Y__N__

AIDS or HIV positive Y__N__

Mental health disturbance or behavioral problems Y__N__

Vision, hearing, tasting or speech issues Y__N__

Excessive bruising, anemia or bleeding disorder Y__N__

Frequent headaches, colds or sore throats Y__N__

Eye, ear, nose or throat condition Y__N__

Hayfever, asthma, sinus trouble or hives Y__N__

Tonsil or Adenoid conditions Y__N__

Fainting, seizures or epilepsy Y__N__

Any other significant medical issues: _____

Any family members with significant medical issues:

Allergies:

Please list all drug, Latex and other allergies: _____

Is patient taking medication, nutrient supplements, herbal medications, or non prescription medicine? Please specify _____

Has patient had any surgeries? Y__N__
If yes, please specify _____

Has patient ever been hospitalized? Y__N__
If yes, please specify _____

Being treated by another health care professional? Y__N__

Please specify _____

Pediatrician _____

Date of last physical exam _____

Results _____

For females:

Has patient started menstruating? Y__N__
At what age _____

Is patient pregnant? Y__N__

Dental History

Dentist _____

Date of last exam _____

Results _____

Now or in the past, has patient had:

Started teething early or late Y__N__

Primary teeth removed that were not loose Y__N__

Permanent or "extra" teeth removed Y__N__

Congenitally missing teeth Y__N__

Chipped or injured baby or permanent teeth Y__N__

Teeth sensitive to hot or cold Y__N__

Jaw fractures, cysts or mouth infections Y__N__

"Dead teeth" or root canals Y__N__

Bleeding gums, bad taste or mouth odor Y__N__

Periodontal "gum" problems Y__N__

Thumb, finger or sucking habit Y__N__

Abnormal swallowing habit (tongue thrust) Y__N__

Mouth breathing habit, snoring or difficulty breathing Y__N__

Tooth grinding, jaw clenching, clicking or locking Y__N__

Pain in jaw or ringing in ears Y__N__

Pain or soreness in muscles of the face or around the ears Y__N__

Difficulty in chewing or jaw opening Y__N__

Aware of loose, broken or missing fillings Y__N__

Taking any forms of fluoride Y__N__

Any relative with similar tooth or jaw relationships Y__N__

Periodontal "Gum" treatment Y__N__

Has patient had any trouble with previous dental treatment? Y__N__

If yes, please specify _____

Ever had a previous orthodontic exam or treatment? Y__N__

If yes, please specify _____

Been in another dentist's care Y__N__

Specialist _____

Other _____

How often does patient brush? _____ Floss? _____

What is your primary concern? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will also inform this practice. I also acknowledge receipt of privacy practices.

Signature _____

Date _____