

# ORTHODONTIC PATIENT INFORMATION

Welcome to our office:

The following information is requested to enable me to give your child the best consideration of his/her orthodontic problem during the initial examination. For me to thoroughly diagnose any condition, I must have accurate background and health information on which to base my decisions. This information, which is important for my records, is confidential. Thank You.

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_  
LAST FIRST M.I. NICKNAME

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
STREET CITY ZIP

School \_\_\_\_\_ Grade \_\_\_\_\_ Patient's E-mail Address \_\_\_\_\_

Physician \_\_\_\_\_ Dentist \_\_\_\_\_ Referred By \_\_\_\_\_

Father/Guardian \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Add: (Same ) \_\_\_\_\_ How Long? \_\_\_\_\_ Social Security # \_\_\_\_\_ Mar. Status \_\_\_\_\_

Employer \_\_\_\_\_ # Yrs. Employed \_\_\_\_\_ Occupation \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Add: (Same ) \_\_\_\_\_ How Long? \_\_\_\_\_ Social Security # \_\_\_\_\_ Mar. Status \_\_\_\_\_

Employer \_\_\_\_\_ # Yrs. Employed \_\_\_\_\_ Occupation \_\_\_\_\_

Person(s) Responsible for Account \_\_\_\_\_ Insurance Carrier \_\_\_\_\_ Insured D.O.B. \_\_\_\_\_

Responsible Party's E-mail Address \_\_\_\_\_

Names and ages of other children in family? \_\_\_\_\_

## Emergency Information

Name of Nearest Relative Not Living With You? \_\_\_\_\_ Relation to Pt. \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

## Medical History (Please Check Those That Apply)

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Nasal / Sinus Problems |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Growth Problems  | <input type="checkbox"/> HIV Positive   | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Blood Disorders            | <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Speech Disorder        |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Mononucleosis  | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Other: (describe below)    |   |   |   |

Comments: \_\_\_\_\_

Is antibiotic medication necessary before dental appointments due to a heart condition? .....  Yes  No

Has the patient been under the care of a physician during the past two years, other than for routine examinations? .....  Yes  No

If yes, why? \_\_\_\_\_

Present drugs or medications: \_\_\_\_\_

Does the patient have any emotional or psychological disturbances? .....  Yes  No

If yes, briefly describe: \_\_\_\_\_

Has the patient experienced a sudden increase in height? .....  Yes  No

If the patient is a male, has his voice changed? .....  Yes  No

has he started to shave? .....  Yes  No

If the patient is female, has she started her monthly period? .....  Yes  No

How long ago? \_\_\_\_\_

Current height? \_\_\_\_\_ Current weight? \_\_\_\_\_

Mother's height? \_\_\_\_\_ Father's height? \_\_\_\_\_

Is the patient adopted? .....  Yes  No

## Respiratory History

### Does the Patient:

1. Have allergies to: Seasonal grasses  Yes  No Foods  Yes  No Metals  Yes  No Latex  Yes  No

Drugs  Yes  No Other: \_\_\_\_\_

If Yes, please specify: \_\_\_\_\_

2. Breathe through mouth regularly? .....  Usually  Sometimes  Seldom

3. Snore when sleeping? .....  Yes  No

4. Has the patient received medical treatment from an allergist or ear, nose, and throat specialist?  Yes  No

If Yes, When? \_\_\_\_\_ By Whom? \_\_\_\_\_

For What? \_\_\_\_\_

5. Have chewing or swallowing difficulty? .....  Yes  No

(Complete Reverse Side)

**Dental History**

Does the patient visit his/her dentist regularly (twice a year)? .....  Yes  No

Last visit to the dentist? \_\_\_\_\_ Teeth cleaned? .....  Yes  No

Has he/she gone through a preventive program with his/her dentist? .....  Yes  No

Daily toothbrushing frequency? 1  2  3  More  Floss Daily? .....  Yes  No

Facial or dental injury due to accidents or blows to the mouth? .....  Yes  No

If Yes, Explain: \_\_\_\_\_

Congenitally missing, extra, or impacted teeth? .....  Yes  No

Has the patient had any teeth extracted due to decay or gum disease? .....  Yes  No

Has the patient ever been treated by a periodontist (Gum Specialist)? .....  Yes  No

If yes, by whom? \_\_\_\_\_ When \_\_\_\_\_

The following habits are of interest. List information as it pertains to patient:

Thumb sucking until age \_\_\_\_\_ Grinding / clenching of teeth .....  Yes  No

Finger sucking until age \_\_\_\_\_ Tongue thrusting .....  Yes  No

Lip-biting or sucking .....  Yes  No Other habits .....  Yes  No

Does the patient have frequent headaches? .....  Yes  No

How often? \_\_\_\_\_ In the morning?  Yes  No In the evening?  Yes  No

Other: \_\_\_\_\_

Location of headaches? \_\_\_\_\_

Has the patient ever experienced pain, clicking, or popping in his/her jaw joints? .....  Yes  No

Pain R  L  Clicking R  L  Popping R  L  Earaches R  L

Has his/her jaw ever locked open? .....  Yes  No Locked Closed? .....  Yes  No

Has the patient ever been treated for temporomandibular joint (TMJ) problems? .....  Yes  No

If yes, by whom? \_\_\_\_\_ When? \_\_\_\_\_

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

Has the patient had orthodontic treatment previously? .....  Yes  No

By whom? \_\_\_\_\_ When? \_\_\_\_\_

Has anyone in your family had orthodontic treatment? .....  Yes  No

Has there been any apprehension or unfavorable experience in a dental office? .....  Yes  No

How does the patient feel about braces? .....  Enthused  OK  Resentful

Is there a family history of similar orthodontic problems? .....  Yes  No If yes, please describe \_\_\_\_\_

Does the patient play a musical instrument with his/her mouth? .....  Yes  No

What type of student is the patient? .....  Excellent  Good  Fair  Poor

What level of cooperation can we expect from the patient? .....  Excellent  Good  Fair  Poor

What is the primary reason for seeking this orthodontic evaluation?

What concerns do you have about braces, orthodontic treatment, etc.?

Are parents aware that some orthodontic appointments will infringe on school time? .....  Yes  No

**Please Read, Sign and Date:** I, the undersigned, verify the accuracy of the above information. If there are any changes in the future, I will inform this practice of these changes. I hereby authorize Dr. Stephen E. Searcy to obtain any information that may be required for credit acceptance in connection with the financial arrangements for orthodontic treatment.

Signature of Parent/Responsible Party

Date

Signature of Witness

Position (TC, etc.)