CHILD'S ORTHODONTIC ACQUAINTANCE

Date:_____

Patient's Name:_____ Nickname:_____

Date of Birth:_____ Age:____ Biological Gender: M/F Identifies as:_____

Address:_____City:_____Zip:_____

Telephone (home) (__)_____Cell Phone (mom/dad)_____

Telephone (mom work) (___)_____ (dad work) (___)_____

Parents Email Address:_____

Dentist_____City_____Telephone (__)_____

Physician_____City_____Telephone (__)_____

School_____City_____Grade_____

Sports/hobbies/etc._____

Family History

Parents:
- ☐ Married
- ☐ Divorced, child lives with _____
- ☐ Separated, child lives with_____
- ☐ Mother deceased
- ☐ Father deceased
- ☐ Child adopted

Responsible Party (financial/ appointment scheduling)_____

Father's name_____Occupation_____

Address_____City_____State___Zip_____

Employer's name and address_____

Mother's name_____Occupation_____

Address_____City_____State___Zip_____

Employer's name and address_____

Names and ages of brothers and sisters_____

Other family members with orthodontic treatment (including parents)_____

Have you had any other experience with or seen another orthodontist? If yes, who _____

Dental Insurance Information

Subscriber name_____Date of birth_____Social Security or ID# _____

Address_____City_____State___Zip_____

Employer name_____

Address_____City_____State___Zip_____

Insurance Company_____

Address_____City_____State___Zip_____

Telephone (___)_____Group #_____

Secondary Dental Insurance Information

Subscriber name_____Date of birth_____Social Security or ID# _____

Address_____City_____State___Zip_____

Employer name_____

Address_____City_____State___Zip_____

Insurance Company_____

Address_____City_____State___Zip_____

Telephone (___)_____Group #_____

Please complete second page

Patient's name:_____

Medical History

General Health: □good □ fair □ poor Presently under medical care for_____

Medication currently being taken (drug and dose)_____

_____

Medication allergies_____

Latex allergies_____

Do you need to premedicate for dental appointments? yes no

Please check yes or no to the following and date:

	yes	no	year		yes	no	year
Adenoids (removed)	y	n	_____	Heart disorder/murmur	y	n	_____
Arthritis	y	n	_____	Hepatitis	y	n	_____
Blood/bleeding problems	y	n	_____	HIV	y	n	_____
Bone disorder	y	n	_____	Hospitalized	y	n	_____
Diabetes	y	n	_____	Lung disorder	y	n	_____
Ear/nose infections	y	n	_____	Rheumatic fever	y	n	_____
Emotional	y	n	_____	Scoliosis	y	n	_____
Endocrine	y	n	_____	Speech difficulty	y	n	_____
Epilepsy	y	n	_____	Tonsils (removed)	y	n	_____
Fainting spells	y	n	_____	Sexually transmitted			
Glaucoma	y	n	_____	infection	y	n	_____
Currently pregnant (females)							

Please give any additional information or details necessary_____

_____

Maturation

Have you grown very much in the past year? yes no How many inches?_____

Female patients: Monthly periods? yes no Started at age_____

Male patients: Voice change? yes no Facial hair? yes no

Dental History

Date of last dental check-up_____

Injury or trauma to the face or teeth_____

Bruxism (teeth grinding) yes no

Clenching teeth yes no

Difficulty sleeping yes no

Mouth breathing yes no

Snoring yes no

Speech (difficulty in pronunciation) yes no

TMJ (Jaw Joint) □ clicking/noise □ pain □ earaches/ringing □ locking

□ muscle soreness □ frequent headaches

Describe major reason for seeking orthodontic treatment_____

Other family members with similar dental conditions_____

Other family members with orthodontic treatment_____

Have you had any experience with or seen another orthodontist?_____

Any additional comments_____

How and when did you first hear about our office?_____

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

Please complete third page

Head and Neck Questionnaire

Name: _____ Age: _____ Sex: _____ Date: _____

1. Do you have frequent headaches?
   Yes No

2. Frequency:
   _____ x/week
   _____ x/month

3. What time of day do you have headaches?
   _____

4. Please check area where head hurts:

5. Do you have clicking, popping or grating noise in your:
   Right jaw joint? Yes No
   Left jaw joint? Yes No

6. Is the pain worse:
   Mornings _____ At meals _____
   Evenings _____ No specific time _____

7. Does the pain sometimes feel like it is in your ear?
   Yes No

8. Has your mouth ever locked open so you were unable to close it?
   Yes No

   Explain: _____
   _____
   _____

9. Have you had problems with other joints?
   Yes No

10. Have you had orthodontic treatment?
    Yes No
    When _____ Where _____

Parent/Responsible Party Signature:_____Date_____