A B C

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's name_____
Last First Middle

Address _____
Street City Postal Code

Nickname_____ Birthdate_____ Age:_____ Sex: **F** or **M**

School_____ Sports/Hobbies_____

Email Address:_____

Mother's name:_____Employer:_____Bus. Tel:_____

Father's name:_____Employer:_____ Bus.Tel:_____

Parents Marital Status: _____Person responsible for account:_____

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

Do you carry orthodontic insurance?:_____If yes (Insurance Carrier):_____

MEDICAL HISTORY

Physician _____Date of Last Visit _____
Address _____Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Is your child taking any medication? _____
Yes No Is your child allergic to any medication? _____
Yes No Does your child have a history of a major illness? _____
Yes No Has your child had any operations? _____
Yes No Has your child ever been involved in a serious accident?_____
Yes No Has your child seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Has menstruation started? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that your child has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____Date of last visit_____
What concerns you most about your teeth? _____

Yes No Is your child presently in any dental pain? _____
Yes No Has your child ever experienced any unfavorable reaction to dentistry? _____
Yes No Has your child ever lost or chipped any teeth? _____
Yes No Has your child ever had any injuries to face, mouth, or teeth? _____
Yes No Is any part of your child's mouth sensitive to temperature? Where? _____
Yes No Is any part of your child's mouth sensitive to pressure? Where? _____
Yes No Do your child's gums bleed when brushing?_____
Yes No Does your child have any type of thumb or tongue habit? _____
Yes No Is your child a mouth breather?_____
Yes No Has your child ever seen an orthodontist? If yes, who and when? _____
Yes No What is your child's attitude toward receiving orthodontic treatment?_____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result?_____
Yes No Do your child's teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Does your child experience jaw clicking or popping? _____

Yes No Are you aware of your child clenching or grinding his/her teeth during the day? _____
Yes No Does your child experience “tension” headaches? _____
Yes No Has your child ever experienced chronic ringing in the ears? _____
Yes No Does your child need extra help with instructions? _____
Yes No Is your child sensitive or self-conscious about his/her teeth? _____
Yes No Height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school hours? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Douglas to perform a complete orthodontic evaluation.

Signature: _____ Date: _____