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:\_\_\_\_\_ Preferred Pronouns:\_\_\_\_\_\_\_\_\_\_\_\_ Sex: **F** or **M**

School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sports/Hobbies

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Bus. Tel:\_\_\_\_\_\_\_\_\_\_

Father’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bus.Tel:\_\_\_\_\_\_\_\_\_\_

Parents Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Person responsible for account:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency contact phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to our office?

**Do you carry dental insurance?:** YES or NO?

If YES, please fill out next section if you are providing **additional** insurance information that we did not collect when this first appointment was originally booked.

Plan holder name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan holder DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan/Contract #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member/Certificate/ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 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 Dental Anxiety Hepatitis/Liver problems Nervous Disorders

ADHD Diabetes Herpes Pneumonia

Anemia Dizziness High Blood Pressure Prolonged Bleeding

Arthritis Epilepsy HIV / Aids Radiation/Chemotherapy

Asthma or Hayfever Gastrointestinal Disorders Kidney problems Rheumatic Fever

Autism Heart Problems Nervous Disorders Tuberculosis

Bone Disorders Heart Murmur Kidney problems Tumor or Cancer

Congenital Heart Defect

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_g

# 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? 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?

 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: