WELCOME TO OUR OFFICE

DATE______________
Updated __________
Updated __________

PATIENT'S NAME______________________________NICKNAME____________________

D.O.B.______________AGE_______ SEX M_____ F______

ADDRESS__________________________________TOWN__________________STATE_____ZIP_______

HOME PHONE:_____________________________Cell/Work PHONE_____________________

PARENT/GUARDIAN FULL NAME____

Home Address________________________________TOWN__________________STATE_____ZIP______

OCCUPATION __________________EMPLOYED BY________________________________

HOME PHONE:_____________________________ Cell/Work PHONE _____________________

PARENT/GUARDIAN FULL NAME____

Home Address________________________________TOWN__________________STATE_____ZIP______

OCCUPATION __________________EMPLOYED BY________________________________

HOME PHONE:_____________________________ Cell/Work PHONE _____________________

PERSON RESPONSIBLE FOR THIS ACCOUNT__________________________________

DO YOU HAVE AN *ORTHODONTIC* INSURANCE PLAN? YES___ NO_____

NAME OF INSURANCE COMPANY?_____________________GROUP #_________________
(note: We ONLY accept DELTA DENTAL ins. but we will provide you with a "superbill" for you to send into your particular insurance company)

GENERAL APRAISAL Who can we thank for your referral?_________________

CHIEF COMPLAINT (REASON FOR CONSULTATION)______________________________________

HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT? _____NO ______YES IF YES,

EXPLAIN____

DOES PATIENT'S PROBLEM RESEMBLE _______FATHER ______MOTHER ______SIBLINGS

OTHER CHILDREN IN FAMILY	AGE	SEX	HAD ORTHO Treatment	NEEDS ORTHO Treatment
________________________	____	____	______________	_________________
________________________	____	____	______________	_________________

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MEDICAL HISTORY

PHYSICIAN/PEDIATRICIAN ______________________________ LAST EXAM _____________

CURRENTLY UNDER MEDICAL TREATMENT ____NO YES__ explain ______________________
HISTORY OF RECENT ILLNESS ____NO YES__ explain ___________________________
CURRENTLY TAKING MEDICATION ____NO YES__ explain ___________________________
EVER BEEN HOSPITALIZED ____NO YES__ explain ___________________________
EVER HAD AN OPERATION ____NO YES__ explain ___________________________
ALLERGIC TO MEDICATIONS ____NO YES__ explain ___________________________
ANY OTHER ALLERGIES ____NO YES__ explain ___________________________
ONSET OF PUBERTY:
BOYS - HAS HIS VOICE CHANGED? ___NO ___YES WHEN___________________
GIRLS - HAS MENSTRUATION BEGUN? ___NO ___YES WHEN___________________

DOES PATIENT HAVE A HISTORY OF:
____ANEMIA ____BONE DISORDERS _____EPILEPSY
____ASTHMA ____KIDNEY DISORDERS _____RHEUMATIC FEVER
____DIABETES ____LIVER INVOLVEMENT _____BLEEDING
PROBLEMS:
____HEART ____FAINTING OR DIZZINESS
_____ENDOCRINE DISORDERS

EXPLAIN ____

DENTAL HISTORY

DENTIST/PEDODONTIST______________ _____________________LAST EXAM_____________

___ THUMB/FINGER SUCKING UNTIL AGE __________
___ MOUTHBREATHING _________AWAKE ________ASLEEP
___ GRINDING OR CLENCHING ____DAY ____NIGHT
___ NAIL-BITING
___ LIP BITING/LICKING
___ BLEEDING GUMS
___ INJURIES TO FACE/MOUTH/TEETH
___ SORENESS OR CLICKING IN JOINT ____NO ____YES

HOW FREQUENTLY DO YOU USE FLOSS _______________________

HAVE YOU BEEN INFORMED OF ANY EXTRA OR MISSING TEETH? ______________

ANY FURTHER COMMENTS: