Child

Patient and Responsible Party Information

Patient Name_____ **Age**_____ **Sex**_____ **Birthdate**_____

Address_____

Address line 2_____ **No. years at address**_____ **Social Security #**_____

Best Phone # to call for appointments_____**E-mail**_____

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

Father's Name_____ Father's Social Security #_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Father's Address_____ Date of birth_____

No. years at address_____Occupation_____Position_____

Employed By_____ No. years employed there_____

Office Address_____ Work Tel. #_____

Home #_____ Cell #_____ Fax #_____

Mother's Name_____ Mother's Social Security #_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Mother's Address_____ Date of birth_____

No. years at address_____Occupation_____Position_____

Employed By_____ No. years employed there_____

Office Address_____ Work Tel. #_____

Home #_____ Cell #_____ Fax #_____

Siblings	**Birth date**
_____	_____
_____	_____
_____	_____

If responsible party is other than the patient or parents, please give information: ☐ Not Applicable

Name_____ Social Security #_____Relationship_____

Address_____ Phone#_____

Medical History

Patient's Family Dentist_____ Phone # _____

Address_____

Patient's Family Physician_____ Phone # _____

Address _____

Emergency Contact (person to contact in case of an emergency)

Name _____ Phone #_____ Relation_____

Does responsible party have Orthodontic Insurance? o Yes o No

MEDICAL HISTORY:

Patient's general health: o Excellent o Good o Fair o Poor

Last complete physical: Date ___/___/___

Has patient had or does patient have any of the following?

	Yes	No		Yes	No
Rheumatic Fever	o	o	Persistent Headaches	o	o
Heart Murmur	o	o	Neck Pains	o	o
High Blood Pressure	o	o	Nerve or Brain Disease	o	o
Heart Attack/Stroke	o	o	Migraine	o	o
Blood Vessel Disease	o	o	Epilepsy	o	o
Blood Disorder	o	o	Mental Health Problems	o	o
AIDS/HIV Infection	o	o	Bone Disorders	o	o
Hepatitis	o	o	Arthritis (any type)	o	o
Diabetes	o	o	Sleep Apnea	o	o
Ulcers	o	o	Ear Disorder	o	o
Herpes (any type)	o	o	Sinus Infection	o	o
Psoriasis	o	o	Swollen Glands	o	o
Cancer	o	o	Allergies	o	o

Comments_____

Please list any other significant information about the patient's medical history:

_____

Yes	No	
o	o	Is patient under a physician's care at present? If yes, reason_____
o	o	Is patient presently, or has patient ever been under the care of a psychiatrist or Psychologist? If yes, describe_____
o	o	Is patient currently taking any medication? If yes, describe_____
o	o	Is the patient allergic to any medications? (Ex.: aspirin, penicillin, etc.) If yes, what?____ _____
o	o	Has patient ever had any general anesthesia? When?_____
o	o	Does patient need to Pre-Medicate?
o	o	If patient is female, has menstrual cycle started?

Please describe why you sought this consultation_____

Has patient ever been treated for this problem before? If yes, please describe the diagnosis and treatment

_____ _____

DENTAL HISTORY

Last dental check-up: Dr._____ Date _____/_____/_____

How often are the teeth brushed daily: _____ Flossed _____Bleeding o Yes o No

Yes	No	
o	o	Does the patient gag easily?
o	o	Do any of your teeth hurt? If yes, upper right o upper left o lower left o lower left o
o	o	Have any wisdom teeth been removed? How many?_____
o	o	Have you ever had treatment for a periodontal disease (gum disease)? If yes, when_____
o	o	Have you ever had any previous orthodontic treatment (braces)? If yes, when_____ If yes, doctor's name and address_____
o	o	Have there been any injuries to your mouth or teeth? If yes, describe_____
o	o	Have you ever been any injury in the head and neck area? If yes, describe_____
o	o	Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe_____
o	o	Have you ever had any surgery in the head and neck area? If yes, describe_____ _____
o	o	Do you clench or grind your teeth? If yes, while sleeping or under stress or other_____
o	o	Do your jaw muscles ever feel tired? If yes, when_____
o	o	Do you ever notice soreness, tightness or pain in the muscles around the jaws and face? If yes, describe_____
o	o	Does it hurt to chew? If yes, where does it hurt?_____
o	o	Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe

describe	Right	Left	Since when	During what activity
o Clicking:	o	o	_____	_____
o Grating:	o	o	_____	_____

Did these joints begin gradually or suddenly: gradually o suddenly o

o	o	Was there some specific event that started the joints sounds? If yes, describe_____
o	o	Have you ever experienced difficulty in opening or closing your jaws? If yes, describe_____ _____
o	o	Have your jaws ever "locked" closed? If yes, describe_____
o	o	Have your jaws ever "locked" wide open? If yes, describe_____
o	o	Do you have pain in your jaws joints? If yes, right o left o since when?_____

Did your pain start gradually or suddenly? o Gradually o suddenly
During what activity?_____ Describe nature of pain_____
What increases the pain _____ What decreases the pain? _____

Do you have any of the following habits?

Yes	No	
o	o	Finger/Thumb sucking
o	o	Nail or Lip Biting
o	o	Tongue thrust habit
o	o	Gum Chewing
o	o	Ice Chewing

Doctors Notes:_____
_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also authorize Dr. Maro, and staff to perform all the necessary procedures deemed appropriate to make a thorough diagnosis of the patient's dental and oral facial needs.

_____ _____
Signature of Patient Date

_____ _____
Doctor's Signature - Orthodontist Date

In order to provide our patients with the best financial terms possible, a soft credit check will be done.
This will not affect your credit score in any way

Signature of Responsible Party_____Date_____

(Office Use Only) **Date Scanned:** _____