ORTHODONTIC INFORMATION RECORD

(Please Print)
TELL US ABOUT YOUR CHILD

Patient's Name______________________ Preferred Name______________________ Male / Female Today's Date____________
Birthdate__________________________ Family Email____
Home Address________________________________ City________________________________ State _______ Zip____________
Responsible Party ____
Mother's Name_________________________ Mother's Cell __________________Home____________________________
Father's Name__________________________ Father's Cell __________________Home____________________________
Patient's School ________________________________ Hobbies/Sports_______________________________________ Grade______
Brother's/Sister's names and ages ____
What is the main thing the patient would like to see us changed about his/her smile? ____________________________
____
How did you hear about our office? ____

ORTHODONTIC INSURANCE INFORMATION

Policy Holder ____ Birthdate _____/_____/______ SS#________________________
Relationship to Patient____________________________________ Employer____
Insurance Co. ____ Insurance Co. Phone____________________________________
Insurance Co. Address ____________________________ City _____________________________ State ______ Zip __________
Group # ____ ID # ____
Do you have dual dental coverage? No [ ] Yes [ ] If yes, please present insurance card.

PATIENT DENTAL HISTORY

Patient's General Dentist ________________________________ Previous orthodontic treatment .... No [ ] Yes [ ]
Approximate last dental visit _____________________________ History of mouth breathing .... No [ ] Yes [ ]
Clenching or grinding teeth .... No [ ] Yes [ ] Clicking/popping in jaws .... No [ ] Yes [ ]
Thumb sucking/tongue thrust/other habits ... No [ ] Yes [ ] Treatment of gum disease .... No [ ] Yes [ ]
Jaw fracture .... No [ ] Yes [ ] Recent injury to head or teeth .... No [ ] Yes [ ]
If you answered yes to any of the above please give a brief explanation: ____
____

PATIENT MEDICAL HISTORY

In good health.. No [ ] Yes [ ]
Currently taking any medication .... No [ ] Yes [ ] If so, please list: ________________________________
Allergic to any medication .... No [ ] Yes [ ] If so, to what? __________________________________
Currently under physician's care .... No [ ] Yes [ ] If so, for what condition? ___________________________

DOES YOUR CHILD HAVE OR HAVE THEY EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS

Artificial bones/joints .... No [ ] Yes [ ] Asthma .... No [ ] Yes [ ]
Attention deficit/Hyperactivity .... No [ ] Yes [ ] Blood disorder/bleeding problems .... No [ ] Yes [ ]
Cancer .... No [ ] Yes [ ] Diabetes .... No [ ] Yes [ ]
Endocrine problems .... No [ ] Yes [ ] Fever Blisters/Herpes .... No [ ] Yes [ ]
Heart condition .... No [ ] Yes [ ] Hepatitis/Liver disease .... No [ ] Yes [ ]
High or low blood pressure .... No [ ] Yes [ ] HIV/AIDS positive .... No [ ] Yes [ ]
Kidney disease .... No [ ] Yes [ ] Psychiatric treatment .... No [ ] Yes [ ]
Polio, mononucleosis, pneumonia............. No [ ] Yes [ ] Radiation treatment .... No [ ] Yes [ ]
Sleep-disorder /airway or sinus problems No [ ] Yes [ ] Speech problems .... No [ ] Yes [ ]
Tuberculosis .... No [ ] Yes [ ] Ulcers/Colitis .... No [ ] Yes [ ]

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the necessary orthodontic services needed during the diagnosis and treatment with my informed consent.

Signature ____

****Please note that some orthodontic appointments will be during school/work hours.****