

I.R. TAKEN _____

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N.P. APPT. _____

CONFERENCE _____

PRACTICE LIMITED TO ORTHODONTICS FOR ADULTS AND CHILDREN

Patient's Name (print) _____
(FIRST) (MIDDLE INITIAL) (LAST)

Address _____ Town _____ Zip Code _____

Male Female Telephone: Home _____ Email Address _____

Whom may we thank for referring you to our office _____ School _____ Grade _____

Birth Date _____ Birthplace _____
(MONTH) (DATE) (YEAR) (CITY) (STATE)

Dentist's Name _____ of _____ Date of Last Dental Checkup _____
(CITY)

Physician's Name _____ Date of Last Medical Checkup _____

Father's Name _____ Mother's Name _____

Father's Date of Birth _____ Mother's Date of Birth _____

Father's Social Security # _____ Mother's Social Security _____

Father's Employer & Address _____ Mother's Employer & Address _____

Father's Business Phone _____ Cell _____ Mother's Business Phone _____ Cell _____

Parents Marital Status: Married () Divorced () Widowed () Separated () Single ()

Other Children's Names and Ages _____

Are any family members currently in treatment? _____ **If so, who?** _____
Currently wearing braces? _____
Wearing Retainers? _____ **Has an appliance?** _____ **Invisalign?** _____
Waiting to begin treatment? _____

1. WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH FOR YOUR CHILD?

2. Is your child in good health? _____ 3. Does your child have regular medical examinations? _____

4. Has your child ever had any of the following (please check)

- | | | | |
|------------------|---------------------|-------------------------------|-------------------------------------|
| Anemia _____ | Hepatitis _____ | Liver or kidney disease _____ | Allergies to any Drugs _____ |
| Diabetes _____ | Hives _____ | Jaw pain _____ | Mitral valve prolapse _____ |
| Asthma _____ | Jaundice _____ | Rheumatic fever _____ | Handicaps or disabilities _____ |
| Epilepsy _____ | Pneumonia _____ | Blood disorders _____ | HIV / AIDS _____ |
| Hay fever _____ | Heart disease _____ | Chronic headaches _____ | ADD / ADHD _____ |
| Hemophilia _____ | Migraines _____ | Fainting _____ | Cancer _____ |

5. Does your child require pre-medication for any condition? _____ If so, for what? _____

6. Is there anything else we should know about your child's general health? Such as allergies to medications, food, Latex, etc _____

7. Has your child ever had any injuries to the face, mouth, teeth, or chin? If yes, please _____

8. Is your child a mouth-breather or thumb sucker? If yes, please explain _____

9. Is there a hereditary background that might contribute to your child's dental problem _____

10. Has your child ever had any pain / tenderness in their jaw joint (TMJ)? _____

11. Other Remarks _____

12. Please indicate any medications that your child is currently taking _____

13. Do you have any Orthodontic Dental Insurance? _____

(Parent or Guardian's signature)

(Today's Date)