

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? _____
Waiting to begin treatment? _____	Invisalign? _____

**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 _____ | <b>Allergies to any Drugs</b> _____ |
| 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)