

New Patient Information Patients Under Age 18

PATIENT

Date _____ Social Security # _____

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ What sex was the patient assigned on their birth certificate? Male Female

What is the patient's current gender identification? Male Female Other

What are the patient's preferred pronouns? _____ School _____ Grade _____

Home address _____ City, State, Zip code _____

Home phone _____ Cell phone _____

PARENT/GUARDIAN

Parent 1/Guardian full name _____

Occupation _____ E-mail address _____

Address (if different) _____

Cell phone (if different) _____ Home phone _____ Work phone _____

Parent 2/Guardian full name _____

Occupation _____ E-mail address _____

Address (if different) _____

Cell phone (if different) _____ Home phone _____ Work phone _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Secondary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medications _____ Taken for _____

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication _____ Taken for ____ Medication _____ Taken for _____

Medication _____ Taken for _____ Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Have you noticed any changes in your face or jaws? _____

Are you pregnant? Yes No Are you trying to become pregnant? Yes No

MEDICAL HISTORY

Now or in the past, have you had:

- Y /N Hereditary or developmental conditions?
- Y /N Bone fractures, or major injuries?
- Y /N Any injuries to face, head, neck?
- Y /N Arthritis or joint problems?
- Y /N Diabetes or low sugar?
- Y /N Kidney problems?
- Y /N Cancer, tumor, radiation treatment or chemotherapy?
- Y /N Stomach ulcer, hyperacidity, acid reflux?
- Y /N AIDS or HIV positive?
- Y /N Hepatitis, jaundice or other liver problem?
- Y /N Mononucleosis, tuberculosis, pneumonia?
- Y /N Seizures, fainting spells, neurologic problem?
- Y /N Vision, hearing, or speech problems?
- Y /N High or low blood pressure?
- Y /N Excessive bleeding or bruising, anemia?
- Y /N Heart defects, heart murmur, rheumatic heart disease?
- Y /N Frequent headaches or migraines?
- Y /N Asthma, sinus problems, hay fever? Tonsil or adenoid condition?
- Y /N Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following:

- Y /N Latex (gloves, balloons)
- Y /N Metals (jewelry, buttons)
- Y /N Acrylics
- Y /N Aspirin
- Y /N Ibuprofen (Motrin, Advil)
- Y /N Penicillin
- Y /N Other antibiotics

DENTAL HISTORY

- Y /N Chipped or injured baby or permanent teeth?
- Y /N Any sensitive or sore teeth?
- Y /N Bleeding gums, bad taste or mouth odor?
- Y /N History of speech problems or speech therapy?
- Y /N Difficulty breathing through nose?
- Y /N Mouth breathing habit or snoring at night?
- Y /N Frequent oral habits (sucking finger, chewing pen, etc)?
- Y /N Tooth grinding or clenching?
- Y /N Clicking, locking in jaw joints?
- Y /N Soreness in jaw muscles or face muscles?
- Y /N Ringing in ears, difficulty in chewing or opening jaw?
- Y /N Have you ever had an orthodontic consultation or treatment before now?

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company. Signature _____

Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____

Date _____

Dental History

Now or in the past, has your child had:

- Y/N Erupting teeth very early or late?
 - Y/N Baby teeth removed that were not loose?
 - Y/N Chipped or injured primary (baby) or permanent teeth?
 - Y/N Any sensitive or sore teeth?
 - Y/N Frequent canker sores or cold sores?
 - Y/N History of speech problems or speech therapy?
 - Y/N Difficulty breathing through nose?
 - Y/N Mouth breathing habit or snoring at night?
 - Y/N* Frequent oral habits (sucking finger, chewing pen, etc?)
*No-Age stopped: _____
 - Y/N* Frequent habit of tongue thrust?
*No-Age stopped: _____
 - Y/N Teeth causing irritation to lip, cheek or gums?
 - Y/N Tooth grinding or clenching?
 - Y/N Clicking, locking in jaw joints?
 - Y/N Soreness in jaw/muscles?
 - Y/N Tension headaches?
 - Y/N Chronic ringing in your ears?
 - Y/N Any serious trouble associated with previous dental treatment?
- Height of parents: Mom: _____ Dad: _____

Medical History

Circle any of the medical conditions now or in the past that your child had or currently has:

- | | | | |
|-------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/ Hemophilia | Diabetes | Hepatitis/Liver Problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV/Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney Problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

Are there any medical conditions not listed you feel we should be aware of? _____

Has your child had allergies or reactions to any of the following?

- | | | |
|-------------------------------|-----------------------|-------------|
| Y/N Latex (gloves, balloons) | Y/N Other antibiotics | Y/N Animals |
| Y/N Aspirin | Y/N Metals | Y/N Foods |
| Y/N Ibuprofen (Motrin, Advil) | Y/N Acrylics | |
| Y/N Penicillin | Y/N Plant Pollens | |

Female Patients:

- Y/N Are you pregnant?
- Y/N Has menstruation started? If yes when _____

RELEASE AND WAIVER I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company. Parent/Guardian Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health. Parent/Guardian Signature _____ Date _____