Date: _____

Welcome

Patient's Name _____Nickname _____ Sex _____

Age _____ Date of Birth _____ home phone number _____

Mailing Address _____ mobile # _____

City _____ State _____ Zip code_____

School _____ Grade _____

Hobbies _____

Referred to this office by _____

Patient's dentist _____

Father's full name _____ Social Security Number _____

DOB _____Employed by _____ Bus. Telephone _____

Mother's full name _____ Social Security Number_____

DOB _____Employed by _____ Bus. Telephone _____

Parents are ----------married _____ separated _____ divorced_____never married _____

Patient resides with whom? _____

Names & ages of other children in family _____

Is the patient adopted? _____ Do you have dental insurance ? _____

Is the patient in good health? _____ Any history of major illness (please explain) _____

_____

Allergies (please list)_____

Check the following previous or current medical conditions:

____AIDS/HIV	____Diabetes	____Hepatitis
____Anemia	____Epilepsy	____Lung disorders
____Arthritis	____Endocrine Disorders	____Nervous disorders
____Asthma	____Fainting or Dizziness	____Pneumonia
____Bleeding disorders	____Heart disorders	____Rheumatic Fever
____Bone disorders	____Kidney Disorders	____Tuberculosis
		____Cerebral Palsy

____other-specify_____

Does patient wear contact lenses? _____Tendency to colds, sore throats, ear infections_____

Have the patient's tonsils and adenoids been removed ? _____

List current medications (prescription or over the counter)_____

When was the patient's last dental examination? _____

Any injuries to the face, mouth, or teeth? _____ Thumb or finger sucking? _____

Is the patient a mouth breather? _____ asleep _____ awake _____

Does the patient grind teeth? _____ asleep _____awake _____

Does the patient have any speech problems? _____ present therapy _____

Does the patient play a musical instrument? _____what kind _____

How often does patient brush teeth:
__ several times a day ___ once a day ___occasionally

Have you been informed of any missing or extra permanent teeth? _____

Patient's height _____ weight _____

Has the patient reached puberty?
Girl- has she started menstruation _____
Boy_ has his voice changed or facial hair growth present _____

Why do you think the patient needs orthodontic treatment? _____

Is the patient aware of this problem? _____

What best describes the patient's attitude toward orthodontic treatment:

__wants treatment ___unwilling, but agrees

__willing if necessary ___uncooperative

Above questions filled out by: _____

Thank you for choosing our office for possible treatment.
Please do not hesitate to ask questions during exam.