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ORTHODONTICS

Member
American Association of
Orthodontists

PATIENT INFORMATION

Date_____

Patient's name_____ Nickname_____ Sex_____

Birthdate_____ Age in years _____ School_____ Grade_____

Home address_____ City/Zip _____ Phone_____

Father _____ Occupation_____

Mother_____ Occupation_____

Parents Marital Status_____

Business name and address of one parent_____ Phone _____

Name and address of person responsible for account_____ Phone_____

Social Security Number _____Drivers License Number_____

Neighbor or relative not living with you_____Phone_____

Is patient covered by orthodontic insurance?_____If yes, please name _____

Family physician _____Family dentist_____

Patient's face and mouth most resemble: Father _____ Mother _____ Patient is adopted _____

Height of patient _____Father _____ Mother _____ Growth of patient last year_____

Describe patients temperament_____ Hobbies/interest_____

Referred by_____

Has patient had previous orthodontic treatment or consultation_____

Do you anticipate a move or transfer in the near future_____

MEDICAL INFORMATION - Check any of the following which apply

❑ Asthma ❑ Blood disease ❑ Diabetes ❑ Rheumatic fever ❑ Hepatitis ❑ Frequent colds

❑ Heart murmur ❑ Endocrine disorders ❑ "Fever blisters" ❑ A.I.D.S. ❑ Freq. headaches

Have tonsils and adenoids been removed_____ At what age_____

Drugs or medication now taking/reasons_____

Drugs or allergy sensitivity_____

Is patient required to take antibiotics prior to dental treatment: ❑ Yes ❑ No

Has patient reached puberty: ❑ Yes ❑ No

Injuries to face, head or teeth_____

Date of last dental visit_____ Has the dentist removed any teeth_____

Habits: ❑ Thumb sucking ❑ Mouth breathing ❑ Nail/Lip biting ❑ Grinding teeth

Jaw joint problems_____

CHIEF COMPLAINT: What is/are your reasons for being here?_____

_____

What would you like orthodontic treatment to accomplish?_____

_____

*All patients must have teeth cleaned and be free from decay before orthodontic treatment can commence.