

Date: _____

Welcome

Patient's Name _____ Nickname _____ Sex _____

Age _____ Date of Birth _____ home phone number _____

Mailing Address _____ mobile # _____

City _____ State _____ Zip code _____

EMAIL ADDRESS _____

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:

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Endocrine Disorders | <input type="checkbox"/> Nervous disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Heart disorders | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Tuberculosis |

COVID-19 _____

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.***