

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

A B C

Date _____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname _____ Birth date _____ Social Security # _____

School _____ Sports/Hobbies _____

Parent or guardian name _____

Sibling Name _____ Date of Birth ___/___/___; Sibling Name _____ Date of Birth ___/___/___

Sibling Name _____ Date of Birth ___/___/___; Sibling Name _____ Date of Birth ___/___/___

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address? _____ Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

Previous Address (If less than 3 years) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Employer _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Member ID _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Employer _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Is the patient taking any medication? List: _____
- Yes No Is the patient allergic to any medication? _____
- Yes No History of a major illness? _____
- Yes No Has the patient had any operations? _____
- Yes No Ever been involved in a serious accident? _____
- Yes No Have seen a physician in the last 12 months? Why? _____
- Yes No Reached puberty? _____

Female Patients only:

- Yes No Has menstruation started?
- Yes No Is the patient pregnant?

Circle any of the medical conditions below that the patient has 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 we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
Address _____ Phone _____

What concerns you most about your teeth? _____

- Yes No Is the patient presently in any dental pain? Where? _____
- Yes No Ever experienced any unfavorable reaction to dentistry? _____
- Yes No Has the patient ever lost or chipped any teeth? _____
- Yes No Have there been any injuries to face, mouth, or teeth? _____
- Yes No Is any part of your mouth sensitive to temperature? Where? _____
- Yes No Is any part of your mouth sensitive to pressure? Where? _____
- Yes No Do gums bleed when brushing? _____
- Yes No Any type of thumb or tongue habit? _____
- Yes No Is the patient a mouth breather? _____
- Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
- Yes No What is the patient's attitude toward receiving orthodontic treatment? _____
- Yes No Has anyone in the family received orthodontic treatment? _____
- Yes No How did they feel about the result? _____
- Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
- Yes No Experience jaw clicking or popping? _____
- Yes No Aware of clenching or grinding teeth during the day? _____
- Yes No Experience "tension" headaches? _____
- Yes No Has the patient ever experienced chronic ringing in the ears? _____
- Yes No Does the patient need extra help with instructions? _____
- Yes No Is the patient sensitive or self-conscious about his/her teeth? _____

Height of birth parents: Mom: _____ Dad: _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. Some appointments must be scheduled during school hours. I have read and understand this paragraph. I also understand that my diagnostic records may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize **Dr. Barbara Perez** to perform a complete orthodontic evaluation.

Signature: _____ Date: _____