

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date _____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname _____ **Birthdate** _____ **Age** _____ **Social Security #** _____

School _____ Sports/Hobbies _____

Parent or guardian name _____

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

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

Other family members seen by us? _____

Who is accompanying the child today? _____ **Relationship to patient?** _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Relationship to patient _____

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

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

Cell/other phone _____ Email address _____

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 _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

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

Insured's Name _____ 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 AND DENTAL HISTORY

Physician _____ Date of Last Visit _____

General Dentist _____ **Date of last visit** _____

What concerns you most about your teeth? _____

Has the child experienced the following medical problems? Please circle Yes or No (If Yes, please fill in details)

- | | |
|------------------------------------|--------------------------------|
| Y N Abnormal Bleeding | Y N Hearing Impairment |
| Y N ADD/ADHD | Y N Heart Murmur |
| Y N AIDS/HIV+ | Y N Hemophilia |
| Y N Any Hospital stays/ Operations | Y N Hepatitis |
| Y N Artificial Bones/Joints/Valves | Y N Kidney Problems |
| Y N Asthma | Y N Liver Problems |
| Y N Cancer | Y N Mitral Valve Prolapse |
| Y N Congenital Heart Defects | Y N Prosthetics |
| Y N Convulsions | Y N Rheumatic Fever |
| Y N Diabetes | Y N Scarlet Fever |
| Y N Epilepsy | Y N Sickle Cell Disease/Traits |
| Y N Handicaps/Disabilities | Y N Tuberculosis (TB) |
| Y N Has Puberty Began | |

Female Patients only:

Yes No Has menstruation started? If yes, what age?

Yes No Is the patient pregnant?

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Please list all drugs that the child is currently taking: _____

Aside from Items listed below, list all drugs/things your child is allergic to: _____

Y N Latex Y N Nickel/Metals Y N Plastic

Does/did the child have any of the following habits:

- | | |
|--------------------------|---------------------------|
| Y N Clenching/Grinding | Y N Nursing Bottle Habits |
| Y N Speech Problems | Y N Lip Sucking/ Biting |
| Y N Thumb/Finger Sucking | Y N Mouth Breather |
| Y N Tongue Thrust | Y N Nail Biting |
| Y N Used Pacifier | |

Yes No Does the patient need extra help with instructions? _____

Yes No Is the patient sensitive or self-conscious about his/her teeth? _____

Yes No Are you aware that some appointments will be during school hours? _____

What is the patient's attitude toward receiving orthodontic treatment? _____

Height of 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. I have read and understand this paragraph. I also understand that my diagnostic records and my name 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. Aiosa to perform a complete orthodontic evaluation.

Responsible Party Signature: _____ Date: _____

Dentist Signature: _____ Date: _____