



# UNDER 18 PATIENT INFORMATION FORM

Welcome to our Office...

Please assist us by completing the following questions...

## CONFIDENTIAL INFORMATION

Date \_\_\_\_\_

## PATIENT INFORMATION

Last Name		First		Middle		Preferred Name	
Address							
City			State			Zip Code	
Home Phone		Date of Birth		Age		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> S.S.N.	
School Attending				Grade		Musical Instrument(s) played	
Favorite Sports, Hobbies & Avocations							
Brothers/Sisters Name(s)				Age(s)			

## RESPONSIBILITY PARTY INFORMATION

Name of Person Responsible for Account		Relationship to Patient	
Father's Name		Address (If different from above)	
Employed by		Work Phone	
Mother's Name		Address (If different from above)	
Employed by		Work Phone	
Do you have Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please provide us with a copy of your insurance card)			
In case we cannot reach you, person(s) to contact		Phone Number	

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing orthodontic treatment. All information will be kept completely confidential.

## MEDICAL HISTORY

Physician's Name: _____			
Address: _____		Phone: _____	
Is the patient in good health?		<input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____	
Does the patient have a history of major illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____	
Is the patient under the care of a physician?		<input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____	
Is the patient taking any medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No List: _____	
Is the patient allergic to: <input type="checkbox"/> penicillin <input type="checkbox"/> codeine <input type="checkbox"/> local anesthetics <input type="checkbox"/> banthine			
Is the patient allergic or sensitive to any other drugs, foods, metals or other products (i.e. latex, nickel)?		<input type="checkbox"/> Yes <input type="checkbox"/> No List: _____	
Has the patient had surgery that involves the placement of a prosthesis (i.e. hip/knee replacement, heart valve, etc.)?		<input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____	
Has the patient had surgery or radiation treatment for a tumor or growth in the head and neck area?		<input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____	
Onset of puberty (approximate date)? _____			
(Boys) Has voice changed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(Girls) Has menstruation began?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient's Height _____		Patient's Weight _____	
Mother's Height _____		Father's Height _____	

Continued...please complete the reverse side

Please check if the patient has had any of the following conditions:

<input type="checkbox"/> HIV Positive/AIDS	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Allergies	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Endocrine Problems
<input type="checkbox"/> Hepatitis Type _____	<input type="checkbox"/> High/Low BP	<input type="checkbox"/> Asthma/Lung Disease	<input type="checkbox"/> Gastric Reflux	<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Liver Disease/Jaundice	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Polio	<input type="checkbox"/> Bone Disorders
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Anemia	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Facial Pain
<input type="checkbox"/> Rheumatic Heart Dis.	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Bulimia
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Degenerative Joints	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Anorexia Nervosa
<input type="checkbox"/> Heart Murmur/Defects	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Emotional Problems	<input type="checkbox"/> Muscular Disorder
<input type="checkbox"/> Heart Trouble/Surgery	<input type="checkbox"/> Lupus/CT Disease	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Fainting Spells
<input type="checkbox"/> Heart Valve Defects	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Other _____

Comments: \_\_\_\_\_

\_\_\_\_\_

DENTAL HISTORY

Dentist's Name \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please check any of the following conditions for which the patient has been diagnosed or treated:**

<input type="checkbox"/> Facial/Teeth/Jaw Injury	<input type="checkbox"/> Tongue Thrust	<input type="checkbox"/> Dead Teeth/Root Canal	<input type="checkbox"/> Ringing in the Ears	<input type="checkbox"/> Mouth Breathing
<input type="checkbox"/> TMJ/TMD/Jaw Problems	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Tooth Sensitivity	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Impacted Teeth
<input type="checkbox"/> Grinding/Clenching Habit	<input type="checkbox"/> Gum Recession	<input type="checkbox"/> Chipped or Broken Teeth	<input type="checkbox"/> Mouth Ulcers	<input type="checkbox"/> Receding Jaw
<input type="checkbox"/> Jaw Clicking/Popping	<input type="checkbox"/> Gum Disease	<input type="checkbox"/> Thumb or finger habit	<input type="checkbox"/> Jaw Cysts/Tumors	<input type="checkbox"/> Other _____
<input type="checkbox"/> Jaw Locking	<input type="checkbox"/> Lip Habit	<input type="checkbox"/> Facial Pain	<input type="checkbox"/> Missing Teeth	<input type="checkbox"/> Other _____

Comments: \_\_\_\_\_

\_\_\_\_\_

**Which of the following are significant concerns?**

<input type="checkbox"/> Crooked/Crowded Teeth	<input type="checkbox"/> Over Developed Jaw	<input type="checkbox"/> Missing Teeth
<input type="checkbox"/> Impacted Teeth	<input type="checkbox"/> Tooth Wear	<input type="checkbox"/> Protruding Teeth
<input type="checkbox"/> Spaced Teeth	<input type="checkbox"/> Extra Teeth	<input type="checkbox"/> Overbite
<input type="checkbox"/> Under Developed Jaw	<input type="checkbox"/> Wisdom Teeth	<input type="checkbox"/> Other _____

Has the patient had a prior orthodontic exam or prior orthodontic treatment?      ☐ Yes      ☐ No

Is the patient currently under a general dentist's care?      ☐ Yes      ☐ No

When was the patient's last dental exam and cleaning? \_\_\_\_\_

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

If so, please explain: \_\_\_\_\_

\_\_\_\_\_

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

\_\_\_\_\_

Signature of Parent or Guardian      Date

**CONSENT FOR DIAGNOSTIC RECORDS**

I consent to the taking of x-rays, models and photographs necessary for diagnostic purposes.

\_\_\_\_\_

Signature of Parent or Guardian      Date

**Who may we thank for your referral?** \_\_\_\_\_