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GETTING TO KNOW YOU

* e-mail?

TODAY'S DATE

PATIENT'S LAST NAME (please print) | First | Middle Initial | AGE (Yrs & Mos.) | NICKNAME | SEX | Mo. | Day | Year

PATIENT'S BIRTHDATE Mo. Day Year | HOME PHONE # ☐ Unlisted | PATIENT'S ADDRESS Street City State Zip Code

LAST NAME - PERSON RESPONSIBLE FOR ACCOUNT | First | Middle Initial | HIS/HER ADDRESS Street City State Zip Code

WHOM MAY WE THANK FOR REFERRING YOU? (Name and Address) | NAME OF PATIENT'S DENTIST City | NAME OF PATIENT'S PHYSICIAN City

ADOPTED? ☐ YES ☐ NO | PRESENT WEIGHT | HEIGHT | MUSICAL INSTRUMENTS PLAYED | PATIENT'S FAVORITE SPORTS | HOBBIES AND AVOCATIONS

PLEASE COMPLETE EITHER A OR B

A

☐ PATIENT IS OLDER THAN 18 YRS. | EMPLOYED AT (Firm, Employer, School) | #Yrs. | OCCUPATION (Student) | POSITION HELD (or Major Study) | PHONE # AT WORK

PATIENT IS ☐ SINGLE ☐ MARRIED TO SPOUSE'S FIRST NAME ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

☐ PATIENT IS YOUNGER THAN 18 YRS. | SCHOOL (or Employer) | GRADE | MARKS | AFTER SCHOOL ACTIVITIES

B

FATHER'S NAME | FATHER'S MARITAL STATUS ☐ REMARRIED ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED | FATHER'S OCCUPATION | FIRM NAME | PHONE# AT WORK

MOTHER'S NAME | MOTHER'S MARITAL STATUS ☐ REMARRIED ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED | MOTHER'S OCCUPATION | FIRM NAME | PHONE# AT WORK

PATIENT LIVING WITH BOTH PARENTS? ☐ YES ☐ NO | IF NO, WITH WHOM IS PATIENT LIVING? | NAME OF RESPONSIBLE PERSON IF NOT PARENT

SIBLINGS IN FAMILY? ☐ YES ☐ NO | NAME (AGE) _____ ( ) _____ ( ) _____ ( ) _____ ( ) _____ ( )

ORTHODONTIC INSURANCE? ☐ YES ☐ NO | NAME OF INSURED | GROUP | POLICY NO. | SOC. SEC NO. | DENTAL INSURANCE CO.

SECOND INS. POLICY? ☐ YES ☐ NO | NAME OF INSURED | GROUP | POLICY NO. | SOC. SEC. NO. | DENTAL INSURANCE CO.

IS THIS A SECOND OPINION? ☐ YES ☐ NO | IF YES, PREVIOUS DR.'S NAME | IS PATIENT UNDER ANY PSYCHOLOGICAL GUIDANCE?

WHAT DO YOU FEEL IS THE MOST IMPORTANT THING YOU CAN GET FROM ORTHODONTIC TREATMENT? | PREVIOUS ORTHODONTIC TREATMENT?

NOW COMPLETE **C** THROUGH **E**. ENCIRCLE OR UNDERLINE CONDITIONS IF **YES** (Feel Free to Use Space at Bottom for Details)

C MEDICAL HISTORY

	NO	YES		NO	YES
Unhealthy Infancy, Breast - or Formula-feeding Difficulty	☐	☐	Polio, Mono, Tuberculosis, Pneumonia	☐	☐
Indigestion, Nausea, Vomiting, Jaundice	☐	☐	Rheumatic Fever, Heart Condition Rheumatism	☐	☐
Diarrhea, Constipation, Abdominal Cramps	☐	☐	High or Low Blood Pressure, Glaucoma	☐	☐
Bone Fractures, Major Accidents	☐	☐	Arthritis, Hepatitis, Recent X-Rays	☐	☐
Change in Weight, Diabetes	☐	☐	Severe Headaches, Colds, Sore Throats Each Year	☐	☐
Hayfever, Asthma, Eczema, Hives	☐	☐	Vision, Hearing Tasting, Speech Difficulties	☐	☐
Extensive Bleeding, Epilepsy	☐	☐	Eye, Ear, Nose, Throat Condition, Skin Disorder	☐	☐
Growths, Tumors, Unusual Swelling	☐	☐	Has Patient Reached Puberty?	☐	☐
Blood in Stools or Urine, Kidney or Bladder Condition	☐	☐	Girls - Has She Started Menstruating?	☐	☐
(Women) Are You Pregnant?	☐	☐	Boys - Has His Voice Changed?	☐	☐
IS PATIENT UNDER PHYSICIAN'S CARE? FOR _____	☐	☐	Other Physical Problems or Symptoms	☐	☐
IS PATIENT ON MEDICATION? PLEASE NAME _____	☐	☐	Allergies or Drug Reactions to _____	☐	☐
Been Hospitalized for _____	☐	☐	Operated on for _____	☐	☐

Do you have any reason to believe that you may have been exposed to HIV? ☐ ☐

D DENTAL HISTORY

	NO	YES		NO	YES
Baby Teeth Came in Early or Late	☐	☐	Tonsils, Adenoids Removed Age _____	☐	☐
Baby Teeth Removed that were Not Loose	☐	☐	Thumb, Finger Sucking Habit. Up to Age _____	☐	☐
Chipped or Injured Baby or Permanent Teeth	☐	☐	Abnormal Swallowing (Tongue Thrust)	☐	☐
Permanent or Extra (Supernumerary) Teeth Removed	☐	☐	Mouth Breathing Habit	☐	☐
Jaw Fractures, Cysts, Abcesses, Other Infections	☐	☐	Difficulty Breathing Through Nose	☐	☐
"Dead Teeth"; Root Canals Treated	☐	☐	Tooth Grinding, Jaw Clenching, Clicking, Locking, Pain	☐	☐
Bleeding Gums, Bad Taste, Mouth Odors	☐	☐	Presently Have Supernumerary or Congenitally Missing Teeth	☐	☐
Gingivitis, Vincent's Infection, Pockets	☐	☐	Aware of Loose, Broken or Missing Fillings	☐	☐
Food Impaction Between Teeth, Periodontal Problems	☐	☐	Concerned About Spaced, Crooked or Protruding Teeth	☐	☐
"Gum Boils", Frequent Canker Sores, Cold Sores	☐	☐	Aware or Concerned About Over or Under Developed Jaw	☐	☐
Wisdom Tooth Problem	☐	☐	Any Relative with Similar Tooth or Jaw Problem	☐	☐
Has Patient Suffered Injury to Face?	☐	☐	Frequent Head, Neck or Backaches	☐	☐

E

Patient's Last Dental Check-Up? _____ X-Rays Taken? _____

Any Previous Orthodontic Treatment? _____ Satisfactory or Not Satisfactory? _____

Has Patient worn a Retainer, Space Maintainer or "Bite Plane"? _____

Would Patient Object to wearing Orthodontic Appliances if they are indicated? _____

What is the Patient's primary concern (why are you here?) _____

Realizing that successful treatment greatly depends on the patient's (and parent's) complete cooperation in following instructions, keeping apointments and maintaing oral hygeine, are there any restrictions, handicaps or problems we might encounter? _____

Please Use This Space for Additional Details