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niepraschk ORTHODONTICS

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's name_____
Last First Middle

Address _____
Street City Zip

Nickname_____ Birthdate_____

Patient's Cell Phone_____ Patient's e-mail_____

(for text reminders, contests, etc.)

School_____ Sports/Hobbies_____

Parent or guardian name _____

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

Have you seen any other orthodontists?_____

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_____

Father

Name _____
Address_____
Phone_____Cell_____
Birth date_____
Business Phone_____
Occupation_____
Employer_____
e-mail_____
Father's Dentist_____
Spouse or SO(if other than mother)_____

Mother

Name _____
Address_____
Phone_____Cell_____
Birth date_____
Business Phone_____
Occupation_____
Employer_____
e-mail_____
Mother's Dentist_____
Spouse or SO(if other than mother)_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature _____

DENTAL HISTORY **Patient Name**_____

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
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? _____
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? _____
Yes No Height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school hours? _____
Yes No ADHD? _____

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? _____
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? _____
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 Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Has patient been diagnosed with ADD or ADHD? _____
Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

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. _____ to perform a complete orthodontic evaluation.

Signature: _____ Date: _____