REQUIRED INFORMATION FOR
ORTHODONTIC TREATMENT

PATIENT'S NAME _____ DATE _____
LAST FIRST INITIAL NICKNAME

HOME PHONE _____ WORK PHONE _____

BIRTHDATE _____ SEX ☐ Male ☐ Female SS# _____ GRADE _____

HOME ADDRESS _____ CITY _____ ZIP _____

REFERRED BY: _____ HOBBY _____

PERSON(S) RESPONSIBLE FOR ACCOUNT: FATHER MOTHER SELF SPOUSE (Circle)

NAME (If Different) _____ SOCIAL SECURITY # _____

EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ CITY _____

BUSINESS PHONE _____ DRIVER'S LICENSE # _____

INSURED BY _____ GROUP # _____

DO YOU HAVE ORTHODONTIC COVERAGE? ☐ YES ☐ NO

NAMES AND AGES OF OTHER CHILDREN IN FAMILY _____

_____

MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING WHICH THE PATIENT HAS HAD:

☐ RHEUMATIC FEVER	☐ ASTHMA	☐ CLICKING/POPPING JAW	☐ HEPATITIS
☐ KIDNEY DISEASE	☐ NECK ACHES	☐ DIABETES	☐ PSYCHIATRIC TREATMENT
☐ FREQUENT HEADACHES	☐ TUBERCULOSIS	☐ EPILEPSY	☐ PAIN AROUND EAR
☐ VENEREAL DISEASE	☐ HIGH BLOOD PRESSURE	☐ RINGING/PLUGGED UP EARS	☐ ANEMIA

DOES THE PATIENT HAVE A TENDENCY FOR: ☐ COLDS ☐ SORE THROATS ☐ EAR INFECTIONS

HAVE THE TONSILS AND/OR ADENOIDS BEEN REMOVED? ☐ YES ☐ NO WHAT AGE? _____

LIST DRUGS NOW BEING TAKEN AND REASONS: _____

_____

LIST ANY DRUG SENSITIVITIES OR ALLERGIES: _____

_____

DENTAL HISTORY

HAVE THERE BEEN INJURIES TO THE FACE, MOUTH OR TEETH? _____ ☐ YES ☐ NO

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____ ☐ YES ☐ NO

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____ ☐ YES ☐ NO

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? _____ ☐ YES ☐ NO

WHILE ASLEEP? _____ ☐ YES ☐ NO

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? _____ ☐ YES ☐ NO

WHICH PARENT DOES THE PATIENT'S ORTHODONTIC PROBLEM RESEMBLE? _____

DID THAT PARENT HAVE ORTHODONTIC TREATMENT? _____ ☐ YES ☐ NO

LIST MUSICAL INSTRUMENTS PLAYED _____

COMPLETE IF PATIENT IS A MINOR:

IS PATIENT GENERALLY COOPERATIVE AT SCHOOL AND HOME TO DIRECTIONS? _____ ☐ YES ☐ NO

DOES THE PATIENT WANT ORTHODONTIC TREATMENT HERSELF/HIMSELF? _____ ☐ YES ☐ NO

HAS THE PATIENT REACHED PUBERTY? GIRLS: HAS SHE STARTED MENSTRUATION? ☐ YES ☐ NO

BOYS: HAS HIS VOICE CHANGED? ☐ YES ☐ NO

IS THE PATIENT LARGE, MEDIUM OR SMALL COMPARED TO OTHERS HIS/HER SAME AGE? _____

AUTHORIZING SIGNATURE _____