PATIENT INFORMATION FORM

Welcome to our office . . .
Please assist us by completing the following questions:

NO. _____

DATE OF EXAM ..... 20.....

DATE OF BIRTH .....

PATIENT'S NAME..... AGE..... SEX .....
Last First Initial

ADDRESS ..... CITY ..... POSTAL CODE ..... PHONE .....

SCHOOL..... GRADE ..... REFERRED BY.....

PATIENT'S DENTIST..... PHYSICIAN .....

NUMBER OF CHILDREN IN FAMILY ..... AGE AND SEX .....

PARENTS MARITAL STATUS: SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ REMARRIED ☐ WIDOW ☐

PATIENT LIVES WITH: BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ ADOPTED ☐

PERSON RESPONSIBLE FOR ACCOUNT.....

ADDRESS..... CITY..... POSTAL CODE .....

DO YOU HAVE AN INSURANCE PLAN WHICH COVERS ORTHODONTIC TREATMENT? YES ☐ NO ☐

FATHER'S NAME..... BUS. TELEPHONE.....

EMPLOYED BY..... OCCUPATION .....

MOTHER'S NAME..... BUS. TELEPHONE.....

EMPLOYED BY..... OCCUPATION.....

MEDICAL HISTORY

Check any of the following the patient has had:

Diabetes ☐	Arthritis ☐	Gland Problems ☐
Pneumonia ☐	Anemia ☐	Prolonged Bleeding ☐
Heart Trouble ☐	Epilepsy ☐	Liver Involvement ☐
Rheumatic Fever ☐	Asthma ☐	Fainting & Dizziness ☐
Bone Disorder ☐	Kidney Involvement ☐	Nervous Disorder ☐

	Yes	No	?
IS THE PATIENT IN GOOD HEALTH?	☐	☐	☐
IS THE PATIENT UNDER PHYSICIANS CARE NOW?	☐	☐	☐
DOES THE PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS OR OPERATIONS?	☐	☐	☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS.....

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LIST ANY ALLERGIES OR DRUG SENSITIVITY.....

DOES THE PATIENT HAVE TENDENCY TO COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE?	☐	☐	☐
HAS PATIENT REACHED PUBERTY? GIRLS - HAS SHE STARTED MENSTRUATION?	☐	☐	☐
BOYS - HAS HIS VOICE CHANGED?	☐	☐	☐
IS THERE ANY HISTORY OF BIRTH DEFECTS?	☐	☐	☐

PATIENT'S HEIGHT..... PARENTS' HEIGHT - MOTHER..... FATHER.....

DENTAL HISTORY

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? If so, describe	☐	☐	☐
HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE?	☐	☐	☐
DOES THE PATIENT HAVE SPEECH PROBLEMS?	☐	☐	☐
IS THE PATIENT A MOUTH BREATHER WHILE AWAKE? Yes ☐ No ☐ ? ☐ ..... WHILE ASLEEP?	☐	☐	☐
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH?	☐	☐	☐
HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC EXAMINATION?	☐	☐	☐
HAS EITHER PARENT OR OTHER CHILDREN HAD ORTHODONTIC TREATMENT?	☐	☐	☐
HAS PATIENT HAD ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR EARS?	☐	☐	☐
DOES THE PATIENT WANT ORTHODONTIC TREATMENT?	☐	☐	☐
WHEN DID THE PATIENT LAST HAVE DENTAL CARE?	☐	☐	☐
IS THERE ANY DENTAL WORK STILL TO BE DONE?	☐	☐	☐
IS THERE ANOTHER FAMILY MEMBER WITH SIMILAR ORTHODONTIC PROBLEMS?	☐	☐	☐
DOES THE PATIENT GRIND OR CLENCH HIS/HER TEETH?	☐	☐	☐
HAVE THE PATIENT'S TEETH ERUPTED EARLY ☐ AVERAGE ☐ LATE ☐	☐	☐	☐
LIST ANY MUSICAL INSTRUMENTS PLAYED	☐	☐	☐

LIST SPORTS, HOBBIES, AND INTERESTS.....

REASON FOR ORTHODONTIC CONSULTATION.....

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Recall..... Parent's Signature .....