

Date: _____ OPMS#: _____

Doctor: **CY D S P**

Location: **J F M P B NL**

Exam With: _____

PATIENT INFORMATION

PATIENT NAME: _____ MALE FEMALE DOB: _____ AGE: _____

PREFERRED NAME: _____ HOBBIES/SPECIAL INTERESTS: _____

ADDRESS: _____ PHONE: (____) _____ CELL: (____) _____

CITY: _____ STATE: _____ ZIP: _____ SCHOOL: _____ GRADE: _____

NAME OF GENERAL DENTIST: _____ PHONE: (____) _____

NAME OF OTHER FAMILY MEMBERS TREATED AT ASSOCIATED ORTHODONTISTS: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

FATHER'S INFORMATION

NAME: _____

BIRTHDAY: _____ SS#: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

EMAIL: _____

PHONE: (____) _____ CELL: (____) _____

CELL PHONE CARRIER (I.E. VERIZON, AT&T): _____

EMPLOYER: _____

MARITAL STATUS:

SINGLE MARRIED SEPARATED DIVORCED WIDOWED DOMESTIC PARTNER

OTHER _____

SPOUSES NAME: _____

MOTHER'S INFORMATION

NAME: _____

BIRTHDAY: _____ SS#: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

EMAIL: _____

PHONE: (____) _____ CELL: (____) _____

CELL PHONE CARRIER (I.E. VERIZON, AT&T): _____

EMPLOYER: _____

MARITAL STATUS:

SINGLE MARRIED SEPARATED DIVORCED WIDOWED DOMESTIC PARTNER

OTHER _____

SPOUSES NAME: _____

ADDITIONAL RESPONSIBLE PARTY INFORMATION - IF APPLICABLE (i.e. stepparent, legal guardian)

NAME: _____ RELATIONSHIP: _____

BIRTHDAY: _____ SS#: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

EMAIL: _____

PHONE: (____) _____ CELL: (____) _____

CELL PHONE CARRIER (I.E. VERIZON, AT&T): _____ EMPLOYER: _____

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED DOMESTIC PARTNER OTHER _____

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE PHONE: _____

GROUP/POLICY #: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

SS#/ID#: _____

INSURED'S EMPLOYER: _____

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE PHONE: _____

GROUP/POLICY #: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

SS#/ID#: _____

INSURED'S EMPLOYER: _____

PATIENT DENTAL/MEDICAL HISTORY

WHY HAVE YOU COME TO THE ORTHODONTIST TODAY? _____

HAS THE CHILD EVER HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH DENTAL WORK? YES NO

HAS YOUR CHILD BEEN SEEN BY AN EAR, NOSE & THROAT (ENT) DOCTOR? YES NO

HAVE THE TONSILS/ADENOIDS BEEN REMOVED? YES NO

IS THE CHILD'S WATER FLUORIDATED? YES NO

IS THE CHILD TAKING FLUORIDATED SUPPLEMENTS? YES NO

HAS THE CHILD EVER HAD ANY PAIN OR TENDERNESS IN THE JAW JOINT? YES NO

HAS THE CHILD EVER HAD ANY TRAUMA TO THE MOUTH OR JAW JOINT? YES NO

PLEASE DESCRIBE TRAUMA: _____

DOES THE CHILD HAVE A HISTORY OF SPEECH PROBLEMS/SPEECH THERAPY? YES NO

DOES THE CHILD HAVE TOOTH SENSITIVITY? YES NO

DOES THE CHILD BRUSH TEETH DAILY? YES NO

FLOSS THEIR TEETH DAILY? YES NO

IS THE CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? YES NO

EXPLAIN: _____

CHILD'S PHYSICIAN: _____

PHONE: (____) _____ LAST VISIT: _____

PLEASE DESCRIBE THE CHILD'S HEALTH: GOOD FAIR POOR

PLEASE LIST ALL DRUGS THE CHILD IS CURRENTLY TAKING: _____

PLEASE LIST ALL DRUGS THE CHILD IS ALLERGIC TO: _____

YES NO

HEART MURMUR

CANCER

DIABETES

RHEUMATIC FEVER

HIV+/AIDS

HEMOPHILIA

ASTHMA

HEPATITIS

TUBERCULOSIS

PROSTHESIS

ALLERGIC TO LATEX & METAL

YES NO

ADD OR ADHD

CONGENITAL HEART DEFECT

CONVULSIONS/EPILEPSY

ABNORMAL BLEEDING

HEARING IMPAIRMENT

ANY OPERATIONS

ANY STAYS IN HOSPITAL

KIDNEY/LIVER PROBLEMS

HANDICAPS/DISABILITIES

ALLERGIES TO ANY DRUGS

HISTORY OF SCARLET FEVER

PLEASE DISCUSS ANY SERIOUS MEDICAL PROBLEMS THAT THE CHILD HAS HAD: _____

DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

THUMB SUCKING / FINGER SUCKING _____ YES NO

LIP SUCKING / BITING _____ YES NO

MOUTH BREATHING _____ YES NO

SNORING _____ YES NO

NAIL BITING _____ YES NO

NURSING BOTTLE HABITS _____ YES NO

ABNORMAL SWALLOWING _____ YES NO

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

Signature of parent/guardian _____

Date: _____