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PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date___________________

Patient's name ____
Last First Middle

Address ____
Street City Zip

Nickname______________________ Birthdate_______________

School___________________________ Sports/Hobbies ____

Parent or guardian name ____

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

RESPONSIBLE PARTY INFORMATION

Name____
Last First Middle

Residence ____
Street City Zip

Mailing Address____
Street City Zip

Home phone_________________________ Work phone ____

Cell/other phone_________________________ Email address ____

Birthdate_________________ Relationship to Patient ____

Employer_____________________________________

Spouse's Name____ Relationship to Patient _______________________

Employer_____________________________________

Birthdate _______________________________________Work Phone __________________

DENTAL INSURANCE INFORMATION

Insured's Name____ Insured's Social Security # ______________________

Insurance Company_________________________ Group No._________________ ID No.___________________________

Insurance Co. Address____ Phone No. _______________________

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name____ Insured's Social Security # _________________________

Insurance Company_________________________ Group No._________________ ID No.___________________________

Insurance Co. Address____ Phone No. _______________________

Emergency Contact Name____ Phone #_________________________

Parent Signature ____

Updates (date & initial) ____

CHILD 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 Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? ______________________
____

DENTAL HISTORY

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?___________________________

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. Cable to perform a complete orthodontic evaluation.

Signature: ____Date: ____________________