PATIENT INFORMATION

Date:_____ Sex: Female Date of Birth:_____

Patient's Name:_____
last first middle

Dentist: _____ Who can we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Responsible Party #1: _____
last first middle

Address: _____
Street City State Zip

Phone:(H)_____ (C)_____ Occupation:_____

E-mail:_____ Employer:_____

Social Security #: ___-___-____Birthdate: ___/___/____ Relation to Patient:_____

Responsible Party #2: _____
last first middle

Address: _____
Street City State Zip

Phone:(H)_____ (C)_____ Occupation:_____

E-mail:_____ Employer:_____

Social Security #: ___-___-____Birthdate: ___/___/____ Relation to Patient:_____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name: _____ Relationship: _____

Insurance Co. Name: _____ Phone# _____

Member ID#: _____ Group#: _____

HEALTH HISTORY **PATIENT NAME:** _____

Has an orthodontist been consulted previously? ☐Yes ☐No
Is the patient having jaw pain or discomfort at this time? ☐Yes ☐No
Does the patient feel very nervous about having ortho treatment? ☐Yes ☐No
Is the patient taking any medications, drugs or pills? ☐Yes ☐No
If yes, reason: _____
Are you aware of being allergic to or have you ever reacted adversely to any medication or substances (Such as latex or any metals) ☐Yes ☐No
If yes, please list: _____
Does the patient require medication prior to dental procedures? ☐Yes ☐No
What are the patient's or parent's primary concerns regarding his or her smile?

_____

Indicate which of the following the patient has had or has present.

Adenoids Removed	☐Yes	☐No	Cosmetic Surgery	☐Yes	☐No	Liver Problems	☐Yes	☐No
AIDS/HIV	☐Yes	☐No	Diabetes	☐Yes	☐No	Kidney Problems	☐Yes	☐No
Anemia	☐Yes	☐No	Emphysema	☐Yes	☐No	Mental Health Issue	☐Yes	☐No
Anorexia/Bulimi	☐Yes	☐No	Endocrine Disorders	☐Yes	☐No	Mononucleosis	☐Yes	☐No
Arthritis	☐Yes	☐No	Epilepsy or Seizures	☐Yes	☐No	Nervousness	☐Yes	☐No
Asthma	☐Yes	☐No	Fainting or Dizziness	☐Yes	☐No	Pneumonia	☐Yes	☐No
ADD	☐Yes	☐No	Hearing Loss	☐Yes	☐No	Pregnant	☐Yes	☐No
Birth Defect	☐Yes	☐No	Heart Pacemaker	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Hereditary Problems	☐Yes	☐No	Surgery	☐Yes	☐No	Rheumatism	☐Yes	☐No
Blood Transfusio	☐Yes	☐No	Heart Trouble	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Bruise Easily	☐Yes	☐No	Hemophilla	☐Yes	☐No	Sickle Cell Disea	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Hepatitis A	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Cold Sores	☐Yes	☐No	Hepatitis B	☐Yes	☐No	Skin Disorder	☐Yes	☐No
Cortisone Medicine	☐Yes	☐No	Immune Disorder	☐Yes	☐No	Stroke	☐Yes	☐No

Additional comments or any other information that you can share that will aid us in treating the patient?

_____

Is the patient on a special diet? ☐Yes ☐No
If yes, what? _____
Does the patient have any disease, condition or problem not listed? ☐Yes ☐No
If yes, what? _____
Have there been any injuries to the face, mouth, or teeth ☐Yes ☐No
If yes, what? _____
Has the patient ever sucked a thumb or finger? ☐Yes ☐No
If yes, are they still? _____
Does the patient have any speech problems? ☐Yes ☐No
If yes, what? _____
Is the patient a mouthbreather? While awake? ☐Yes ☐No While asleep? ☐Yes ☐No
Has the patient ever been informed of any missing or extra permanent teeth? ☐Yes ☐No
If yes, which ones? _____

I have read and understand the proceeding questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

CONSENT: The undersigned hereby authorizes Pediatric Dental Professionals to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of the patients dental needs. I also authorize Pediatric Dental Professionals to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that PDP choose to employ such assistance as deemed fit.

Signature (Parent's signature if minor) _____