Information
WE NEED TO KNOW YOU BETTER

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ORTHODONTICS

Patient Information

Date _____

Patient's name _____ Date of Birth _____ Age _____ Sex F M

Address _____ Tel.(H) _____

_____ Tel.(C) _____

E-mail Address _____

Whom do we thank for referring you to us? ☐ Facebook ☐ Instagram ☐ Website ☐ Advertisement ☐ Yellow Pages

☐ Staff ☐ Family/Friend/Dentist/Other _____ Tel: _____
Name of Referrer

Patient's Dentist _____ Patient's Physician _____

If a minor: Parent's/guardian's name _____

Responsible Party Information

Name _____ Date of birth _____ Martial Status _____

Residence _____ Tel.(H) _____ Tel.(W) _____

E-mail: _____ Cell: _____ TRN: _____

Mailing Address _____

No. of years at this Residence _____ Relationship to Patient _____

Employer _____ Occupation _____ No. of yrs. employed _____

Emergency Information

Name of nearest relative **not** living with you _____

Address _____ Tel. _____

Medical History

Is the patient in good health? ..... ☐ Yes ☐ No

Does the patient have any history of major illness?..... ☐ Yes ☐ No

If yes, explain: _____

Is the patient currently being treated by a physician?..... ☐ Yes ☐ No

If yes, what condition? _____

_____

Check any of the following for which the patient has been treated:

☐ Diabetes	☐ Tuberculosis	☐ Hormonal problems	☐ Pneumonia
☐ Anemia	☐ Bleeding problems	☐ Heart trouble	☐ Epilepsy
☐ Fainting/dizziness	☐ Rheumatic fever	☐ Asthma	☐ Neurologic disorders
☐ Bone disorders	☐ Kidney problems	☐ Liver problems	☐ HIV or AIDS related condition
☐ Hypertension	☐ Behavioral Problems	Other _____	
☐ **None of these**			

Please Turn Over

Is the patient pregnant? ..... ☐ Yes ☐ No

Have tonsils or adenoids been removed? ..... ☐ Yes ☐ No

Does the patient have any allergies? ..... ☐ Yes ☐ No

List them: _____

Does the patient have any sensitivity to drugs, e.g. penicillin, aspirin?..... ☐ Yes ☐ No

List them: _____

Is the patient taking any medication at this time?..... ☐ Yes ☐ No

List them: _____

Has the patient reached puberty? Girls: Has she started menstruation? ..... ☐ Yes ☐ No

Boys: Has his voice changed?..... ☐ Yes ☐ No

Has the patient experienced any significant growth in the past 6 month? ..... ☐ Yes ☐ No

Height of mother _____ Height of father _____

Dental History

Have there been any injuries to the face, mouth or teeth?..... ☐ Yes ☐ No

If yes, explain _____

Has the patient ever sucked thumb or fingers?..... ☐ Yes ☐ No

If yes, until what age?_____

Is the patient a tongue sucker?..... ☐ Yes ☐ No

Does the patient have a speech problem? ..... ☐ Yes ☐ No

Is the patient a mouth breather? ..... ☐ Yes ☐ No

Check if the patient has had problems with any of the following:..... ☐ Yes ☐ No

☐ Cavities ☐ Teeth sensitive to hot/cold ☐ Gum infection ☐ Toothaches

☐ Teeth sensitive to sweets ☐ Colour of Teeth ☐ Other dental problems ☐ None of these

What is your main reason for seeking orthodontic advice or treatment?

_____

_____

_____

Printed Name (Parent/Guardian/Patient)

_____

Signature (Parent/Guardian/Patient)