Patient Information

Child's Name: _____
Last First Middle

Nickname: _____ _____Male _____ Female School _____Grade____

Address _____
Street City Zip

Home Phone (_____)_____-_____ Birth date: _____/_____/ 19_____ Age: _____

Who is accompanying the child today: _____ Relation: _____

Do you have legal custody of this child? _____Yes _____No

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

Parent's Information

Mother:

Name: _____ Birth date: ____/_____/_____

Marital Status: _____Single ____Married _____Widowed _____Divorced _ __Remarried

Mailing Address_____
Street City Zip

Home #: (____)_____-_____ Cell #: (____)_____-_____ E-mail address: _____@_____

Relationship to Patient: _____ Employer: _____ Title: _____

Spouse's Name: _____ Birth date: ____/_____/_____

Relationship to Patient: _____ Employer: _____ Title: _____

Father:

Marital Status: _____Single ____Married _____Widowed ____Divorced ____Remarried

Name: _____ Birth date: ____/_____/_____

Mailing Address_____
Street City Zip

Home #: (____)_____-_____ Cell #: (____)_____-_____ E-mail address: _____@_____

Employer: _____ Title: _____

Spouse's Name: _____ Employer: _____ Title: _____

Who is responsible for account? _____

Dental Insurance Information

Dental Coverage: ____ Yes ____ No Orthodontic Coverage: ____ Yes ____ No

Insured's Name: _____D.O.B._____ Insured's Social Security #_____-_____-_____

Insurance Company: _____ Group #: _____ ID #: _____

Insurance Co. Address_____ Phone #:_____

MEDICAL HISTORY

Physician: _____ Date of Last Visit: _____/_____/_____

Please **CIRCLE** Yes or No to the following questions (If Yes, please fill in details):

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any major operations? _____
Yes No Have there been any injuries to the face, mouth, teeth or chin? _____

CIRCLE any of the medical conditions below that you have had or currently have:

Abnormal Bleeding/Hemophilia	Epilepsy	Nervous Disorders	ADD/ADHD
Gastrointestinal Disorders	Herpes	Rheumatic Fever	Anemia
Handicap/Disability	Radiation/Chemotherapy	Asthma or Hayfever	Sickle Cell
Kidney Problems	Hearing Impairment	Heart Murmur	Cancer
Liver Problems	Tuberculosis	Congenital Heart Defect	Diabetes
Mitral Valve Prolapse	Hepatitis/Liver problems		

Please list any medical conditions we have not discussed that you feel we should be aware of: _____
_____

CIRCLE any allergic reactions to the following:

Yes	No	Aspirin	Yes	No	Erythromycin	Yes	No	Penicillin
Yes	No	Codeine	Yes	No	Jewelry/Metals	Yes	No	Tetracycline
Yes	No	Dental Anesthetics	Yes	No	Latex	Yes	No	Other

Please list any other drugs / materials that you are allergic to:
_____

PATIENT DENTAL HISTORY

Dentist: _____Date of last visit: _____/_____/_____

What concerns you most about the patient's teeth? _____

CIRCLE Yes or No to following for the patient being seen today:

Yes No Are you presently in any dental pain? Explain: _____
Yes No Have you ever experienced any unfavorable reaction to dentistry?
Explain: _____
Yes No Have you ever lost or chipped any teeth?
Yes No Is any part of your mouth sensitive to temperature or pressure?
Yes No Do your gums bleed when they brush?
Yes No Do you have any type of thumb or tongue habit?
Yes No Are you a mouth breather?
Yes No Have you seen an orthodontist? If yes, who and when? _____
Yes No Would you object to wearing orthodontic appliances (braces)?
Yes No Has anyone in your family received orthodontic treatment? If so, who? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
Yes No Is the patient experiencing any jaw clicking or popping? Explain:_____

Dental History continued:

Yes No Are you aware of clenching your teeth during the day?
Yes No Have you ever been told that you grind your teeth?
Yes No Do you have "tension" headaches?
Yes No Have you ever experienced chronic ringing in your ears?
Yes No Are you aware that some appointments will be during school/work hours?
Yes No Are you pregnant?
Yes No Do you have any missing or extra permanent teeth?
Yes No Do you have any speech problems?

Are you happy with the way your smile looks? ____ Yes ____ No

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 the patient's diagnostic records and his/her 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. Skelton to perform a complete orthodontic evaluation on the patient named on this form.

Signature: _____ Date: _____

Acknowledgment of Privacy Policy

I,_____(please print first and last name), am aware that a copy of this office's Notice of Privacy Practices is available at request.

In subject of minor child, I have listed below four persons who may be involved in his/her orthodontic updates and/or transportation.

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____
4. _____ Relationship to Patient: _____