

**PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE**

A B C

Date \_\_\_\_\_

Patient's name \_\_\_\_\_

Last

First

Middle

Address \_\_\_\_\_

Street

City

Zip

Nickname \_\_\_\_\_ Birthdate \_\_\_\_\_ School \_\_\_\_\_

Sports/Hobbies \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_

Last

First

Middle

Mailing Address \_\_\_\_\_

Street

City

Zip

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell/other phone \_\_\_\_\_

Email address \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Member 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. \_\_\_\_\_ Member No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

**EMERGENCY INFORMATION**

Name of nearest relative not living with you \_\_\_\_\_

Mailing address \_\_\_\_\_

Street

City

Zip

Phone \_\_\_\_\_

Parent Signature \_\_\_\_\_

**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 Do you still have your Tonsils/Adenoids? \_\_\_\_\_
- 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. Robert Bourquein to perform a complete orthodontic evaluation.

Signature: \_\_\_\_\_