



Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: MM / DD / YY Age: \_\_\_\_\_ Sex: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Tel: \_\_\_\_\_

Number of Children in Family: \_\_\_\_\_ Ages & Names of Other Children: \_\_\_\_\_

Patient's Dentist: \_\_\_\_\_ Physician: \_\_\_\_\_ Physician's Tel: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_ Parent/Guardian's e-mail (to confirm appointments): \_\_\_\_\_

Responsible Party 1: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Tel: \_\_\_\_\_

Daytime Tel: \_\_\_\_\_ [ ] Work [ ] Cell [ ] Home

Responsible Party 2: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Tel: \_\_\_\_\_

Daytime Tel: \_\_\_\_\_ [ ] Work [ ] Cell [ ] Home

Person Responsible for Account (insurance holder) \_\_\_\_\_

Do you have an insurance plan that covers orthodontic treatment? [ ] Yes [ ] No [ ] Unsure

MEDICAL HISTORY - HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?

Table with 3 columns of medical conditions and checkboxes for Yes/No. Conditions include Rheumatic Fever, Heart Murmur, Mitral Valve Prolapse, Heart Disease, Artificial Heart Valve, Artificial Joints, Tuberculosis, H.I.V./A.I.D.S., Hepatitis A, B, or C, Sexually Transmitted Diseases, Blood Disease, Prolonged Bleeding, Diabetes, Kidney Disorder, Liver Disease, Asthma, Arthritis, and Other.

If you responded YES to any of the above, please give pertinent information: \_\_\_\_\_

Is the child in good health? \_\_\_\_\_

Does the child have any history of major illness and/or operations? \_\_\_\_\_

List any drugs or medications now being taken: Please give reasons: \_\_\_\_\_

List any allergies or drug sensitivities (including sensitivity to metals) \_\_\_\_\_

Does the child have a tendency to colds? [ ] Yes [ ] No Sore Throats? [ ] Yes [ ] No Ear Infections? [ ] Yes [ ] No

Have the tonsils or adenoids been removed? [ ] Yes [ ] No If so, at what age? \_\_\_\_\_

Has the patient reached puberty? Girls-Has menstruation started? [ ] Yes [ ] No Boys-Has voice changed? [ ] Yes [ ] No

DENTAL HISTORY

Has the child ever been treated for a jaw joint problem, including surgery? [ ] Yes [ ] No Please describe \_\_\_\_\_

Have there been any injuries to the face, mouth or teeth? [ ] Yes [ ] No Please describe \_\_\_\_\_

Has the child ever sucked his/her thumb or finger? [ ] Yes [ ] No Until what age? \_\_\_\_\_

Does the child have any speech problems? [ ] Yes [ ] No

Does the child have frequent canker or cold sores? [ ] Yes [ ] No

Is the child a mouth breather? While Asleep: [ ] Yes [ ] No While Awake: [ ] Yes [ ] No

Have you been informed of any missing or extra permanent teeth? [ ] Yes [ ] No

Has the child ever had a previous orthodontic examination? [ ] Yes [ ] No

Is the child especially apprehensive towards dental visits? [ ] Yes [ ] No

Does the child want orthodontic treatment? [ ] Yes [ ] No

Has any other family member had braces or orthodontic treatment? [ ] Yes [ ] No

Please name the family member if treated in our office: \_\_\_\_\_

When did the child last see the family dentist? \_\_\_\_\_

List any sports, hobbies or musical instruments: \_\_\_\_\_

Reason for orthodontic treatment: \_\_\_\_\_

RELEASE OF INFORMATION: I hereby give Dr. J. Daskalogiannakis and/or members of his staff permission to release information concerning my dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records pertaining to the initial condition, diagnosis, proposed treatment or treatment in progress.

Signature

Date