



### Patient Information (if a minor)

School \_\_\_\_\_ Grade \_\_\_\_\_  
Siblings: Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_  
Siblings: Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_  
Patient's Hobbies or Interests \_\_\_\_\_

### Dental History

Patient's Dentist \_\_\_\_\_ Date of last dental cleaning and check-up \_\_\_\_\_  
Why are you seeking orthodontic treatment? \_\_\_\_\_  
Have there ever been any injuries to the face, mouth, or teeth? Yes  No   
If yes, explain \_\_\_\_\_  
Has the patient ever sucked a thumb or finger? Yes  No  Until what age? \_\_\_\_\_  
Have you been informed of any missing or extra permanent teeth? Yes  No   
Has an orthodontist been consulted previously? Yes  No   
Has the patient had any previous orthodontic treatment? Yes  No   
If yes, name & address of previous orthodontist? \_\_\_\_\_  
Has any other family member had orthodontic treatment? Yes  No   
If treated by this practice, please list their names \_\_\_\_\_  
Would patient object to wearing orthodontic appliances (braces) if indicated? Yes  No   
Comments \_\_\_\_\_  
Additional information which you feel would help make your child's association with us more enjoyable? \_\_\_\_\_

### Medical History

Any major or unusual illness? Yes  No  Explain: \_\_\_\_\_  
Currently under physician's care? Yes  No  Reason: \_\_\_\_\_  
Currently taking medication? Yes  No  List: \_\_\_\_\_  
Allergies Yes  No  List: \_\_\_\_\_  
Drug sensitivity Yes  No  List: \_\_\_\_\_

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Sinus problems / frequent cough |
| <input type="checkbox"/> Blood disease               | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Hearing problems                |
| <input type="checkbox"/> Prolonged bleeding          | <input type="checkbox"/> Endocrine problems  | <input type="checkbox"/> Tonsillitis / Adenitis          |
| <input type="checkbox"/> Hepatitis, liver disease    | <input type="checkbox"/> Bone disorders      | <input type="checkbox"/> Asthma                          |
| <input type="checkbox"/> AIDS / AIDS related complex | <input type="checkbox"/> Epilepsy / seizures | <input type="checkbox"/> Mouth breathing                 |
| <input type="checkbox"/> Rheumatic fever             | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Emotional problems              |
| <input type="checkbox"/> Heart / lung disease        |  |  |

### Growth Information for Patients Under 16 Years of Age

Father's Height: \_\_\_\_\_ Mother's Height: \_\_\_\_\_ Adopted? Yes  No   
Patient Resembles: Neither parent  Mother  Father   
Girls: Has she started menstruation? Yes  No  When? \_\_\_\_\_  
Boys: Has his voice changed? Yes  No  When? \_\_\_\_\_