



In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

Patient Information – Child or Teen

Patient Name: _____ Age: _____ Date of Birth: _____

Parent/Guardian#1: _____ Parent/Guardian#2: _____

Family member(s) we are currently /previously treating in Ortho. _____

Best day time phone # _____ HOME/CELL/WORK (Circle) Relationship _____

Alternate phone #: _____ HOME/CELL/WORK (Circle) Relationship _____

Email _____

Dental History

What are your orthodontic concerns? _____

- ☐ Yes ☐ No Have there been any severe injuries to the face? Please describe _____
- ☐ Yes ☐ No Does the patient have a heart condition that may predispose them to infective endocarditis?
If so, does that patient require preventative antibiotics before certain dental procedures?
☐ Yes ☐ No
- ☐ Yes ☐ No Does the patient have a prosthetic joint and may be at risk for developing hematogenous infection at the site of the prosthetic?
- ☐ Yes ☐ No Are you aware of any missing or extra teeth? Which ones? _____
- ☐ Yes ☐ No Does the patient suck a thumb, fingers, tongue, blanket or pacifier? (Circle which)
If so, until what age? _____
- ☐ Yes ☐ No Does the patient breathe predominantly through the mouth?
- ☐ Yes ☐ No Has the patient seen a periodontist, endodontist, or oral surgeon? _____
- ☐ Yes ☐ No Has the patient had previous orthodontic treatment or consultation? _____
- ☐ Yes ☐ No Has any member of the family had orthodontic treatment? _____
- ☐ Yes ☐ No Does the patient have any dental, facial pain or joint pain?
- ☐ Yes ☐ No Does the patient habitually grind or clench teeth together?
- ☐ Yes ☐ No Does the patient have any negative or resistant feelings about orthodontic treatment?
Specifically, ☐ Braces, ☐ Headgear, or ☐ Retainers?
- ☐ Yes ☐ No Is the patient dissatisfied about the appearance of their teeth, smile, gums, chin, nose or lips? (if yes, circle all that apply) _____
- ☐ Yes ☐ No Is there any other dental information we should know? _____

Signature: _____ Date: _____

(Responsible party signature if patient is a minor)

