PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date ________________________

Patient's Name: Last ________________________ First ____________________________ Middle ____________
Address: Street ________________________________City _______________________ Postal _________________
Nickname _______________________ Birthdate _______________________ School ________________________
Sports / Hobbies ____
Parent or guardian name ____
Whom may we thank for referring you to our office? ____

RESPONSIBLE PARTY INFORMATION

Name: Last _______________________________ First ___________________________Middle _______________
Residence: Street _______________________________City _______________________Postal _______________
Mailing Address: Street ___________________________________City ___________________Postal ____________
How long at this address? ____________________Home # ____________________Cell #____________________
Work # ___________________________Email address ____
Spouses Name ____________________________________Relationship to patient __________________________

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 Has the patient 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/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 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 the mouth sensitive to temperature? Where? _______________________________
Yes No Is any part of the 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 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 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 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. Matheson to perform a complete orthodontic evaluation.

Signature ____ Date _______________________________________