SMILES BY DESIGN
ORTHODONTICS

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Patient Information

Patient Name: _____ Preferred Name:_____

Date of Birth: _____/_____/_____ Gender: ☐ M ☐ F

Home Address:_____

Home Phone:_____ Cell Phone: _____Work Phone:_____

Best way to reach you during business hours: ☐ Home ☐ Cell ☐ Work

Height:_____ Weight:_____ Last Dental Check up:_____

School:_____ Grade:_____ Email:_____

Number of children in family:_____ Age / Sex:_____

Please list other family members we have treated:_____

Other family members have had: ☐ Braces ☐ Jaw Surgery ☐ Other: _____

Do you have orthodontic insurance coverage? ☐ No ☐ Yes (please specify): ☐ Self ☐ Other:_____

Fathers Name:_____ Phone Number:_____ Employed By:_____

Mothers Name:_____ Phone Number:_____ Employed By:_____

Patients Family Physician: _____ Patient's Family Dentist: _____

Whom may we thank for referring you to our office: _____

Medical History

Please check any of the following for which the patient has been treated:

- ☐ ADD or ADHD
- ☐ Anemia
- ☐ Hay Fever
- ☐ Stomach Problems
- ☐ Asthma
- ☐ Autism
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Endocrine (Hormonal)
- ☐ Epilepsy / Seizures
- ☐ Fainting & dizziness
- ☐ Growth Disorder
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ HIV / AIDS
- ☐ Diabetes
- ☐ Latex Allergy
- ☐ Liver Problems
- ☐ Mononucleosis
- ☐ Nervous Disorders
- ☐ Rheumatic Fever
- ☐ Thyroid
- ☐ Kidney Problems
- ☐ Hepatitis
- ☐ Bleeding Disorders
- ☐ Bone Disorders
- ☐ Hearing Problems
- ☐ Ear Aches
- ☐ Eye Problems
- ☐ Other:_____

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YES NO

☐ ☐ Have the patients tonsils and adenoids been removed? If yes, at what age? _____

☐ ☐ Has the patient reached puberty?

☐ ☐ Girls- Has she started her menstruation?

☐ ☐ Boys- Has his voice changed?

Dental History

Please answer the following questions:

YES NO

☐ ☐ Does the patient have any speech problems?

☐ ☐ Have you been informed of any missing or extra permanent teeth?

☐ ☐ Does the patient have frequent colds or canker sores?

☐ ☐ Is the patient apprehensive toward dental visits?

☐ ☐ Have there been any injuries to the head, face, mouth or teeth?_____

☐ ☐ Has the patient ever sucked their thumb or finger? If yes, until what age?_____

☐ ☐ Is the patient a mouth breather? If yes, while awake or asleep?_____

☐ ☐ Does the patient want orthodontic treatment?_____

Who first noticed the need for orthodontic treatment?

How often does the patient go to their dentist?_____

List any musical instruments played_____

List any sports played_____

Is there a history of:

☐ ☐ Lip biting

☐ ☐ Tooth grinding or clenching

☐ ☐ Difficulty chewing

☐ ☐ Pain in ear region

Reason for seeing us in your own words:_____

_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to infrom this office. I also give my permission for clinical examination.

_____ _____

SIGNATURE DATE