ORTHODONTIC ASSOCIATES OF NORTH TEXAS, PA

Date _____

Patients name _____ Nickname _____
Home address _____City _____ State _____ Zip _____Telephone ( )_____
School (employer)_____ Grade _____ Date of birth _____/_____/_____ age_____ sex _____
Referred by _____ Patient's Dentist _____ Patient's Physician_____
Father's name _____ Birth Date _____/ _____/ _____
Address (if different) _____ Social Security # _____
Employer _____ Work telephone ( ) _____
Dental Insurance _____ Mobile telephone ( ) _____
Mother's name _____ Birth Date _____/_____/_____
Address (if different) _____ Social Security # _____
Employer _____ Work telephone ( ) _____
Dental Insurance _____ Mobile telephone ( ) _____
Person financially responsible _____ Social Security # _____
Address (if different from patient) _____ Telephone ( ) _____
EMAIL ADDRESS FOR CONFIRMATIONS _____

GENERAL APPRAISAL

Why did you make this appointment? _____
What is your concern about your child's teeth? _____
List names and ages of other children in the family. _____
Do any of your other children have similar orthodontic problems? _____
Have any members of your family received orthodontic treatment? Y / N Who? _____ When? _____
Has this patient been evaluated or treated by another orthodontist? _____
Would this patient mind wearing braces? _____ Functional appliances_____ Retainers _____ Rubber bands _____
Any noticeable difficulty in chewing or swallowing food? Y / N _____
Has this patient ever been teased about the appearance of his/her teeth Y / N _____
Are you aware that some appointments will infringe on **school time** or **work time** Y / N _____
Hobbies, Activities, Special interest _____

MEDICAL HISTORY

Is patient in good health? Y / N explain _____
Does patient have any history of major illness? Y / N explain _____
Check any of the following for which the patient has been treated:

__ Diabetes	__Rheumatic Fever	__Epilepsy	__Kidney Involvement	__Fainting/dizziness
__ Pneumonia	__ Bone disorders	__Anemia	__ Endocrine problems	__ Nervous disorders
__ Heart trouble	__ Tuberculosis	__ Asthma	__ Prolonged bleeding	__ Liver involvement

Have tonsils/adenoids been removed? Y / N what age? _____
List any allergies or drug sensitivities_____
Does patient have tendency to _____ Colds _____ Sore throats _____ Ear infections_
Please list any medications being taken at this time_____
Any allergies to **latex** or **metals**? _____ yes _____no
Has this patient reached puberty? Y / N

DENTAL HISTORY

Have there been any injuries to face, mouth, or teeth? Y / N _____
Have you been informed of any missing or extra permanent teeth? _____
Does patient have any speech problems? Y / N _____
Has the patient ever sucked a thumb or finger? Y / N until what age? _____
Is the patient a mouth breather? Y / N while awake? _____ While asleep? _____
How long since last dentist visit? _____
List any musical instruments played by patient _____

_____
Signature of person responsible for account