

PATIENT INFORMATION (UNDER 18)

Date _____

Patient's name _____
Last First Middle

Age _____ Birthdate: _____ Gender: M F Nickname/Preferred Name _____

Who is accompanying the child today? _____ **Relation to patient** _____

Do you have legal custody of this child? Y N If not, NAME OF LEGAL GUARDIAN: _____

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

PARENT/LEGAL GUARDIAN INFORMATION

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____

Spouse's Name _____ Relationship to Patient _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ D.O.B. _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Employer _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ D.O.B. _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? **PLEASE LIST ALL MEDICATIONS:** _____
- Yes No Are you allergic to any medication? **PLEASE LIST DRUG ALLERGIES:** _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any operations? _____
- Yes No Have you ever smoked or chewed tobacco? _____
- Yes No Have you ever been involved in a serious accident? _____
- Yes No Have seen a physician in the last 12 months? Why? _____
- Female Patients only:
- Yes No Are you pregnant? **If so, # of weeks and due date:** _____
- Yes No Has menstruation started? **If yes, age at first menstrual period:** _____

Circle any of the medical conditions below that you have had or currently have:

- | | | | |
|------------------------------|-----------------------------|-------------------------------|------------------------------|
| Allergy to latex or metals | Artificial Valves or Joints | Drug/Alcohol Abuse | Sexually Transmitted Disease |
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness/Vertigo | Herpes/Fever blister/Shingles | Radiation/Chemotherapy |
| Arthritis | Epilepsy/Seizures | High/Low Blood Pressure | Rheumatic Fever |
| Asthma/Hay Fever/Sinusitis | Gastrointestinal Disorders | HIV / AIDS | Thyroid Disease |
| Bone Disorders | Heart Problems/Stroke | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Mental/Behavioral Disorders | Tumor or Cancer |
| Hearing/Vision Problem | Migraine headaches | Apnea | Osteoporosis |

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? (crowding, overbite, underbite, spacing, missing teeth, buck teeth, etc) _____

What is your attitude toward receiving orthodontic treatment? (Excited, nervous, don't want braces, etc) _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you presently in any dental or jaw pain? _____
- Yes No Have there been any injuries to the face, mouth, or teeth? _____
- Yes No Have you ever been told that you are missing permanent teeth? _____
- Yes No Do you have any teeth that are stuck in the jaw (impacted)? _____
- Yes No Have you had your wisdom teeth removed? _____
- Yes No Do you have any type of thumb- or finger-sucking habit? _____
- Yes No Do you have a cleft lip and/or palate? _____
If yes, date of alveolar bone graft (if applicable): _____
Approximate date of next surgery: _____
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
- Yes No Do your teeth or jaws ever feel uncomfortable? _____
- Yes No Are you aware that some appointments will be during school/work hours? _____

Please list some hobbies or interests _____

PLEASE READ AND SIGN:

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I attest that I have legal custody of this child and I authorize Dr. Dana M. Casaus to perform a complete orthodontic evaluation.

Signature: _____ Date: _____