Date___________________

Personal Information

Patient's full name____ Nickname (if preferred) __________________________

Birthdate(d/m/y) _________________________ Age_____ Gender_________

Address____
Street City Postal Code

Phone____ Email Address____

Mother's name__________________________________ Employer___________________________ Cell_____________________

Father's name___________________________________ Employer___________________________ Cell____________________

If address different from above: _____________________________ Person responsible for account __________________________

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

Do you carry orthodontic insurance? ____________________ If yes (Insurance Carrier) ____________________________________

Insurance Policy holder: (name)______________________________(birthdate d/m/y)______________________________________

Insurance Policy numbers: __________________________________ ____

Siblings____

School___________________________ Sports/Activities ____

Medical History

Physician____ Date of Last Visit_____________________________

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

_______Abnormal Bleeding
_______ADD/ADHD
_______Allergies (latex, metals, plastic, meds, etc.)
_______Anemia
_______ Any hospital stays
_______Any Operations________
_______Arthritis
_______ Autism Spectrum
_______Asthma / Hay Fever
_______Blood Transfusion
_______Bone Disorders
_______Cancer or Tumor
_______Congenital Heart Defects

_______Convulsions / Epilepsy
_______Diabetes
_______ Dizziness / Fainting
_______Emotional Problems
_______Gastrointestinal Disorders
_______Handicaps / Disability
_______Hearing Impairment
_______Heart Attack / Stroke
_______ Heart Murmur
_______Heart Surgery
_______Hepatitis / Liver Problems
_______Herpes / Fever Blisters
_______ High Blood Pressure
_______HIV+ / AIDS

_______ Kidney Problems
_______Lupus
_______Mitral Valve Prolapse
_______ Nervous / Psychiatric Disorder
_______ Pneumonia
_______Radiation / Chemotherapy
_______Rheumatic / Scarlet Fever
_______Shingles
_______Sickle Cell Disease
_______Sinus Problems
_______Tuberculosis (TB)
_______Venereal Disease

Are there any medical conditions we have not discussed that you feel we should be aware of? _________________________
____

Please list all medications your child is currently taking? ____
____

Yes or No Is your child currently under the care of a physician?____

Yes or No Has Puberty begun? ____

Dental History

General Dentist ____ Date of last visit______________________________

What concerns you and your child most about your child's teeth? ____
____

Yes	No	
☐	☐	Is your child presently in any dental pain? ____
☐	☐	Has your child ever experienced any unfavorable reaction to dentistry? ______________________________
☐	☐	Has your child ever lost or chipped any teeth? ____
☐	☐	Has your child ever had any injuries to face, mouth, or teeth? _____________________________________
☐	☐	Does your child have any type of thumb or finger habit? ____
☐	☐	Does your child have any type of tongue habit or speech problems?_________________________________
☐	☐	Is your child a mouth breather? ____
☐	☐	Does your child grind or clench his/her teeth? ____
☐	☐	Does your child experience jaw clicking, popping, locking, or pain?_________________________________
☐	☐	Does your child experience frequent headaches? ____
☐	☐	Does your child need extra help with instructions?____
☐	☐	Is your child sensitive or self-conscious about his/her teeth? ____ _________________________________
☐	☐	What is your child's attitude toward receiving orthodontic treatment? _______________________________
☐	☐	Has your child ever seen an orthodontist? If yes, who and when? ___________________________________
☐	☐	Has anyone in the family received orthodontic treatment? ____

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 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 authorize Dr. Millar to perform a complete orthodontic evaluation.

Signature: ____ Date: ____________________