



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)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abnormal Bleeding                              | <input type="checkbox"/> Convulsions / Epilepsy     | <input type="checkbox"/> Kidney Problems                |
| <input type="checkbox"/> ADD/ADHD                                       | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Lupus                          |
| <input type="checkbox"/> Allergies (latex, metals, plastic, meds, etc.) | <input type="checkbox"/> Dizziness / Fainting       | <input type="checkbox"/> Mitral Valve Prolapse          |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Emotional Problems         | <input type="checkbox"/> Nervous / Psychiatric Disorder |
| <input type="checkbox"/> Any hospital stays                             | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Pneumonia                      |
| <input type="checkbox"/> Any Operations _____                           | <input type="checkbox"/> Handicaps / Disability     | <input type="checkbox"/> Radiation / Chemotherapy       |
| <input type="checkbox"/> Arthritis                                      | <input type="checkbox"/> Hearing Impairment         | <input type="checkbox"/> Rheumatic / Scarlet Fever      |
| <input type="checkbox"/> Autism Spectrum                                | <input type="checkbox"/> Heart Attack / Stroke      | <input type="checkbox"/> Shingles                       |
| <input type="checkbox"/> Asthma / Hay Fever                             | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Sickle Cell Disease            |
| <input type="checkbox"/> Blood Transfusion                              | <input type="checkbox"/> Heart Surgery              | <input type="checkbox"/> Sinus Problems                 |
| <input type="checkbox"/> Bone Disorders                                 | <input type="checkbox"/> Hepatitis / Liver Problems | <input type="checkbox"/> Tuberculosis (TB)              |
| <input type="checkbox"/> Cancer or Tumor                                | <input type="checkbox"/> Herpes / Fever Blisters    | <input type="checkbox"/> Venereal Disease               |
| <input type="checkbox"/> Congenital Heart Defects                       | <input type="checkbox"/> High Blood Pressure        |   |
|   | <input type="checkbox"/> HIV+ / AIDS                |   |

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                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Is your child presently in any dental pain? _____                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child ever experienced any unfavorable reaction to dentistry? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child ever lost or chipped any teeth? _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child ever had any injuries to face, mouth, or teeth? _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any type of thumb or finger habit? _____                |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any type of tongue habit or speech problems? _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your child a mouth breather? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child grind or clench his/her teeth? _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child experience jaw clicking, popping, locking, or pain? _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child experience frequent headaches? _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child need extra help with instructions? _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your child sensitive or self-conscious about his/her teeth? _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | What is your child's attitude toward receiving orthodontic treatment? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child ever seen an orthodontist? If yes, who and when? _____        |
| <input type="checkbox"/> | <input type="checkbox"/> | 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: \_\_\_\_\_

