



Date _____

Patient Information

Name _____

Sex _____ Age _____ Birthdate _____ School _____ Grade _____
Last First Middle

Favorite Interests (i.e. Hobbies, sports, etc) _____

General Dentist _____ Physician _____

Dental Specialist (i.e. Periodontist, Oral Surgeon, etc) _____

Names of any other family members treated in our office? _____

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

What are your chief concerns regarding your child's orthodontic condition? (Overbite, crowding, etc.)

Mother

Father

Name _____

Name _____

Birthdate _____

Birthdate _____

Social Security # _____

Social Security # _____

Address _____

Address _____

Home Phone _____

Home Phone _____

Cell Phone _____

Cell Phone _____

E-mail address _____

E-mail address _____

Employed By _____

Employed By _____

Work Phone _____

Work Phone _____

Insurance Provider _____

Insurance Provider _____

Policy # _____

Policy # _____

Marital Status: Married Single Divorced

Medical History

Physician _____ Date of Last Visit _____

Address _____ Phone _____

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

Yes No Is your child taking any medication? _____

Yes No Is your child allergic to any medication? _____

Yes No Does your child have a history of a major illness? _____

Yes No Has your child had any major operations? _____

Yes No Has your child ever been involved in a serious accident? _____

Select any of the medical conditions below that apply to your child.

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

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

Dental History

Dentist _____ Date of last visit _____

- Yes No Has your child ever seen an orthodontist? If yes, who and when? _____
- Yes No Does your child/would your child have any problems chewing gum? _____
- Yes No Does your child/would your child have any problems chewing bagels or other hard foods? _____
- Yes No Do your child's teeth or jaws ever feel uncomfortable when waking in the morning? _____
- Yes No Are you aware of your child's jaw clicking or popping? _____
- Yes No Are you aware of your child clenching his/her teeth? _____
- Yes No Does your child have frequent headaches? _____
- Yes No Has your child ever experienced chronic ringing in his/her ears? _____
- Yes No Is your child presently in any dental pain? _____
- Yes No Has your child ever experienced any unfavorable reaction to dentistry? _____
- Yes No Has your child ever lost or chipped any teeth? _____
- Yes No Has your child ever lost or chipped any teeth? _____
- Yes No Has your child ever had any facial or dental injuries? _____
- Yes No Does your child have more than one bite or do you clench (squeeze) to make your teeth fit together? ____
- Yes No Does your child have any problems with sleep or wake up with an awareness of their teeth? _____
- Yes No Does your child have problems with their jaw joint? (pain, sounds, limited opening, locking, popping) ____
- Yes No Does your child have tension headaches or a history of migraines? _____
- Yes No Is your child currently experiencing any dental pain or sore teeth? _____
- Yes No Do your child's gums bleed when brushing or flossing? _____
- Yes No Does your child wear or have they ever worn a bite appliance? _____
- Yes No Has your child experienced any injuries to face, mouth or teeth? _____
- Yes No Does your child have any speech problems? _____
- Yes No Does your child have any thumb/finger habits? _____

Please note any other factors that are relevant to your dental health. _____

Authorization

I authorize the release of medical and dental information to insurance carriers, other health care providers in my dental care, and the use of records by Dr. Rosenzweig for teaching purposes or scientific publication.

In the future, please advise the doctor of any changes in your medical or dental health while under care in this office.

Signature: _____

Date: _____