ROSENZWEIG ORTHODONTICS
Central Oregon's Smile Specialists

Date_____

Patient Information

Name_____
Last First Middle

Sex_____ Age_____ Birthdate_____ School_____ Grade_____

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
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma or Hayfever
- ☐ Bone Disorders
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Gastrointestinal Disorders
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis/Liver problems
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV / Aids
- ☐ Kidney problems
- ☐ Nervous Disorders
- ☐ Pneumonia
- ☐ Prolonged Bleeding
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ 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 had an unfavorable dental experience? _____
- ☐ Yes ☐ No Has your child ever seen an orthodontist? If yes, who and when? _____
- ☐ Yes ☐ No Is there anything about the appearance of your child's teeth that is of specific concern? _____
- ☐ Yes ☐ No Is your child self conscious about his/her smile? _____
- ☐ Yes ☐ No Are your child's teeth crowding or developing spaces? _____
- ☐ Yes ☐ No Have your child's teeth changed in the last 2-3 years, become shorter, thinner, or worn? _____
- ☐ Yes ☐ No Does your child have more than one bite or do they clench (squeeze) to make their teeth fit together? __
- ☐ 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 clenching/grinding his/her teeth? _____
- ☐ Yes ☐ No Does your child have probelms with their jaw joint? (pain, sounds, limited opening, locking, popping) ___
- ☐ Yes ☐ No Does your child have frequent headaches? _____
- ☐ Yes ☐ No Has your child ever lost or chipped any teeth? _____
- ☐ Yes ☐ No Has your child ever had any injuries to the face, mouth, or teeth? _____
- ☐ Yes ☐ No Is your child currently experiencing any dental pain or sore teeh? _____
- ☐ Yes ☐ No Do your child's gums bleed when brushing or flossing? _____
- ☐ Yes ☐ No Does your child have 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: _____

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