

Preliminary Ortho Exam

Patient name _____ Sex _____ Birthdate _____ Age _____
Address _____ City _____ Zip _____ Phone# _____
Patient's dentist _____ City _____ Physician _____ City _____
Referred by _____ City _____ School _____ Grade _____
E-mail address (optional) _____

Responsible Party Information:

Mother _____ Marital status _____
Address _____ City _____ Zip _____ Phone# _____
Occupation _____ Work phone# _____ Date of birth _____
Employer _____ No. years employed _____

Father _____ Marital status _____
Address _____ City _____ Zip _____ Phone# _____
Occupation _____ Work phone# _____ Date of birth _____
Employer _____ No. years employed _____

Insurance Information:

Mother's SS# _____ - _____ - _____ Insurance company _____ Group No. _____
Father's SS# _____ - _____ - _____ Insurance company _____ Group No. _____

Medical History:

Has the patient been under the care of a physician during the last five years? _____ Please elaborate _____
Drugs or medications now being taken / reasons _____
Has the patient had any of the following? Yes No (If yes, please circle):
Rheumatic fever, hepatitis, HIV, diabetes, heart disease, asthma, T.B., kidney or liver involvement, hormonal imbalance,
epilepsy, cerebral palsy, fainting, allergies (hay fever, etc.), ADHD, bleeding problems, nervous disorders.
Is patient in good health? _____ Please elaborate _____
Is patient a mouth breather? Yes No Ear infections, Tonsils, adenoids involvements? Yes No
Has patient reached puberty? _____ Menstration (girls) age _____ Voice change (boys) age _____
Injuries to face, head or teeth _____
Jaw joint problems? (TMJ), i.e. popping, clicking, pain, etc. _____
For emergencies, please give us the name of the nearest relative not living with you:
Name _____ Address _____ Phone _____

Dental History:

What is the primary concern about patients teeth? _____
Last visit to dentist _____ Were X-Rays taken? Yes No
Difficulty chewing _____ Swallowing _____ Speaking _____
Did patient suck thumb or finger? Yes No Please elaborate _____
Career goals/Activities & Hobbies _____
If treatment is recommended what kind of braces would you prefer? Traditional silver or clear braces Invisalign
Other orthodontic consultations and or treatment? Yes No
If yes: When _____ Where _____

Parent's Signature _____ Date _____

I have received a copy of the medical information privacy notice.
Also, I understand that credit bureau reports may be obtained.