

**CHILD'S MEDICAL AND DENTAL INFORMATION
 PRELIMINARY INFORMATION**

Today's Date _____

Patient's Name _____ Nickname _____ Sex _____
Last First Middle

Date of Birth _____ / _____ / _____ Age in Years _____ School _____ Grade _____
mo. day yr

Home Address _____ Phone _____
Street No. Street Name

City _____ State _____ Zip _____

Parent's address if different _____

Previous Address _____ City and Zip _____
Street No. Street Name

Father's Name _____ Social Sec. No. _____ Age _____
Last First Middle

Father's Occupation _____ Business Phone No. _____

Business Address _____
Street No. Street Name City State Zip

Mother's Name _____ Social Sec. No. _____ Age _____
Last First Middle

Mother's Occupation _____ Business Phone No. _____

Business Address _____
Street No. Street Name City State Zip

Person Responsible for Account If Now Divorced or Separated _____

Whom may we thank for referring you to this office? _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Pol. # _____

Insurance Co. _____ Group # _____

Insured's Employer _____

MEDICAL HISTORY

The patient's Medical and Dental History information is very important. This information bears directly on the outcome of treatment and is also important in helping to avoid complications. Thank you for taking the time to answer these questions.

1. Is patient in good health? Yes No
2. Has there been any change in patient's general health within the past year? Yes No
3. Patient's last physical examination was on _____
4. Is patient now under the care of a physician? Yes No
 If so, what is the condition being treated? _____
5. The name and address of patient's physician(s) is _____

6. Is patient taking any medicine(s) including non-prescription medicine? Yes No
 If so, what medicine(s) are being taken? _____
7. Has patient had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
 If so, what was the illness or problem? _____
8. Does patient have tendency to sore throats? If yes, how often? Yes No
 Does patient have tendency to ear aches? If yes, how often? Yes No
 Have Tonsils and Adenoids been removed? If yes, when? Yes No
 Does patient have tendency to colds? If yes, how often? Yes No
9. Has patient had any injuries to the face, head or teeth? If yes, please give complete details including date(s) of occurrence, nature of injury and who treated: _____

10. Does patient have or has patient had any of the following diseases or problems?
 - a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? Yes No
 - b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) Yes No
 1. Pain in chest upon exertion? Yes No
 2. Ever short of breath after mild exercise or when lying down? Yes No
 3. Do ankles swell? Yes No
 4. Have inborn heart defects? Yes No
 5. Have a cardiac pacemaker? Yes No
 6. Ever had heart surgery? Yes No
 - c. Allergy Yes No
 - d. Sinus trouble Yes No
 - e. Asthma or hay fever Yes No
 - f. Fainting spells or seizures, dizziness Yes No

g. Persistent diarrhea or recent weight loss	Yes	No
h. Diabetes	Yes	No
i. Hepatitis, jaundice or liver disease	Yes	No
j. AIDS or HIV infection	Yes	No
k. Thyroid problems	Yes	No
l. Respiratory problems, emphysema, bronchitis, etc.	Yes	No
m. Arthritis or painful swollen joints	Yes	No
n. Stomach ulcer or hyperacidity	Yes	No
o. Kidney trouble	Yes	No
p. Tuberculosis	Yes	No
q. Persistent cough or cough that produces blood	Yes	No
r. Persistent swollen glands in neck	Yes	No
s. Low blood pressure	Yes	No
t. Sexually transmitted disease	Yes	No
u. Epilepsy or other neurological disease	Yes	No
v. Problems with mental health	Yes	No
w. Cancer	Yes	No
x. Problems of the immune system	Yes	No
y. Alcoholism or drug dependency or addiction	Yes	No
aa. Scarlet Fever	Yes	No
bb. Chemotherapy	Yes	No
cc. Radiation Therapy	Yes	No
dd. Cortisone Therapy	Yes	No
ee. Cosmetic Surgery	Yes	No
ff. Diabetes	Yes	No
gg. Rheumatism	Yes	No
hh. Epilepsy	Yes	No
ii. Chicken Pox	Yes	No
jj. Fever Blisters	Yes	No
kk. Glaucoma	Yes	No
ll. Measles	Yes	No
mm. Mumps	Yes	No
nn. Nervousness/anxiety	Yes	No
oo. Psychological treatment	Yes	No
pp. Psychiatric Treatment	Yes	No
qq. Ulcers	Yes	No
11. Has patient had abnormal bleeding?	Yes	No
a. Has patient ever required a blood transfusion	Yes	No
12. Does patient have any blood disorder such as anemia, hemophilia, leukemia, sickle cell disease?	Yes	No
a. Does patient bruise easily	Yes	No
13. Has patient ever had any treatment for a tumor or growth?	Yes	No
14. Is patient allergic or have you had a reaction to:		
a. Local anesthetics	Yes	No
b. Penicillin or other antibiotics	Yes	No
c. Sulfa drugs	Yes	No
d. Barbiturates, sedatives, or sleeping pills	Yes	No
e. Aspirin	Yes	No
f. Iodine	Yes	No
g. Codeine or other narcotics	Yes	No
h. Other _____		
15. Has patient had any problems associated with any previous dental treatment?	Yes	No
If so, explain _____		
16. Does patient have any disease, condition, or problem not listed above that you think I should know about?	Yes	No
If so, explain _____		
17. Is patient wearing contact lenses?	Yes	No
18. Is patient wearing removable dental appliances?	Yes	No
Women		
19. Is patient pregnant?	Yes	No
20. Does patient have any problems associated with your menstrual period?	Yes	No
21. Is patient nursing?	Yes	No
22. Is patient taking birth control pills?	Yes	No
23. Is there any other medical (health) information you would like us to know? If yes, please explain _____	Yes	No

The medical information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s) in my health and of recent visits to my physician at my next visit. In addition, I authorize Dr. Finkelson to perform a complete orthodontic examination.

_____ Date _____ Signature

Are there brothers or sisters whose development we can follow?

name/birthdates _____

name/birthdates _____

name/birthdates _____

DENTAL HISTORY

GENERAL DENTAL INFORMATION

1. When was patient's last dental visit? _____
2. How frequently does patient visit his or her dentist? _____
3. The name and address of patient's dentist is: _____

4. When was patient's last full mouth or panoramic series of x-rays? _____
5. Is patient having any dental problems now? Yes No
If yes, please specify _____

6. I would describe patient's temperament as: _____
7. Patient's hobbies or sports interests are: _____
8. Do you anticipate a move or transfer in the near future? Yes No
If yes, please explain _____
9. Are you pleased with the way patient's teeth look? Yes No
If no, please explain _____
10. Has patient reached puberty? Yes No
11. Is patient's teeth discolored? Yes No
12. Is patient unhappy with his or her smile? Yes No
13. Has patient ever been in an auto accident? Yes No
If yes, please explain _____

14. Has patient ever had an injury to patient's head, face, or neck? Yes No
If yes, please explain _____
15. Has patient ever had teeth removed? Yes No
16. Has patient's wisdom teeth been removed? Yes No
If yes, when and by whom? _____
17. Is patient a mouth breather? Yes No
18. Has patient ever had a finger or thumb habit? Yes No
19. Are patient's teeth sensitive to cold, hot or foods? Yes No
20. Would patient mind wearing braces? Yes No
If yes, please explain _____
21. What is patient's main reason for seeking orthodontic treatment? _____

22. Please specify any other reasons patients has for seeking orthodontic treatment? _____

ORTHODONTIC INFORMATION

1. Has patient ever had orthodontic treatment (braces)? Yes No
If yes, when and by whom _____
2. Has patient ever had an orthodontic examination, evaluation, conference or consultation? Yes No
If yes, when and by whom _____
3. Has patient ever had orthodontic records, such as x-rays, study models or photographs? Yes No
If yes, when and by whom _____
4. Do you feel patient's teeth can be straighter? Yes No
5. Do you feel patient's occlusion (bite) needs to be improved? Yes No
6. Has patient ever been told to see an orthodontist? Yes No
If yes, when and by whom _____

PERIODONTAL (GUM) INFORMATION

1. Do you feel patient's gingiva (gums) are healthy? Yes No
If no, please explain _____
2. Do patient's gums bleed when brushing? Yes No
3. Has patient's gums ever bled when brushing? Yes No
4. Does patient regularly use dental floss or tape? Yes No
If yes, since when? _____
5. Have you or patient ever been told that patient has gum disease? Yes No
If yes, when and by whom? _____
6. Has patient ever been advised to have periodontal (gum) treatment? Yes No
7. Has patient ever had a periodontal examination? Yes No
If yes, when and by whom? _____
8. Has patient ever had periodontal (gum) treatment? Yes No
If yes, when and by whom _____
9. Will patient follow instructions regarding good oral hygiene? Yes No
10. Has patient ever been told or have you or patient ever noticed that your gums are receding? Yes No
If yes, please explain _____

HEAD, NECK, TMJ (JAW JOINT) INFORMATION

1. Do you feel patient's jaw joint is healthy?	Yes	No
If no, please explain		
2. Does patient's jaw joint(s) click, crack, pop, grate or make any other sound(s)?	Yes	No
If yes, please explain		
3. Has patient's jaw joint(s) ever made any of the above or other sounds?	Yes	No
If yes, please explain		
4. Does patient grind teeth?	Yes	No
5. Does patient clench teeth?	Yes	No
6. If patient is experiencing stress, does patient grind teeth?	Yes	No
7. Does patient ever have or has patient ever had jaw soreness, jaw pain, muscle soreness (jaw area) neck soreness?	Yes	No
If yes, please explain		
8. Does patient now or has patient previously experienced aches or pains in the following areas:		
a. Front of the head	Yes	No
b. Over the eyes	Yes	No
c. Sinus area	Yes	No
d. Temple area	Yes	No
e. Cheeks or side of the face	Yes	No
f. Top of the head	Yes	No
g. Back of the head	Yes	No
h. Back of the neck	Yes	No
i. Side of the neck	Yes	No
j. Tongue or under the tongue	Yes	No
k. Front of the neck	Yes	No
l. Shoulders	Yes	No
m. Upper back	Yes	No
n. Lower back	Yes	No
o. Other pain, please describe	Yes	No
For the above problems, what circumstances seem to cause the problem(s), make it worse or make it better?		
a)		
b)		
c)		
9. Does patient now or has patient previously experienced ear aches, ear pain, stuffiness in his or her ear(s), reduced hearing or loss of hearing?	Yes	No
If yes, please explain		
10. Has patient's jaw ever "locked" open or closed?	Yes	No
If yes, please explain		
11. Has patient ever been told that patient has a TMJ or "Jaw Joint" problem?	Yes	No
If yes, when and by whom		
12. Has patient ever been advised to have treatment for a TMJ or "Jaw Joint" problem?	Yes	No
If yes, when and by whom		
13. Has patient ever had treatment for a TMJ "Jaw Joint" Problem?	Yes	No
If yes, when and by whom		
14. Has patient ever worn a splint or nightguard appliance for any reason?	Yes	No
If yes, please explain		
15. Has patient ever had a TMJ or "Jaw Joint" examination?	Yes	No
If yes, when and by whom		
16. Has patient ever been told that you have jaw arthritis?	Yes	No
If yes, when and by whom		

The dental information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s) in patient's dental health and of recent visits to patient's dentist at the next visit.

_____ Date _____ Signature _____

FOR OFFICE USE ONLY

Comments concerning medical history: _____

Significant findings _____

Orthodontic management considerations: _____

_____ Date _____ Examining Dentist _____

Medical/Dental history update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____