PATIENT INFORMATION

Date: _____

Patient's Legal Name: _____
(Last) (First) (Middle)

Patient's Nickname: _____ Date of Birth: _____ Age: _____ years ____months
Mo. Day Yr.

Patient's Address: _____
(Street) (City) (Zip)

Home phone: _____ Patient lives with: ( ) Both Parents Together ( ) Father Primarily ( ) Mother Primarily

Is orthodontic insurance available? ( ) None ( ) Father ( ) Mother ( ) Both ( ) Step-Father ( ) Step-Mother

Patient's Dentist:_____ **You were recommended to our office by:**_____

FAMILY INFORMATION

Father: Mr. / Dr. / Rev. / Rabbi _____
(Circle One) (Last Name) (First Name) (Middle Initial)

Social Security Number*: _____ Date of Birth: _____

Address *(if different from patient's)*: _____

Home Phone *(if different from patient's):* _____Cell: _____

Work Phone: _____ Email: _____

Occupation: _____ Employer: _____

Name of Dental Insurance Company: _____ *(Please give dental card to receptionist to copy for file.)*

Mother: Mrs. / Miss / Ms. / Dr. / Rev. _____
(Circle One) (Last Name) (First Name) (Middle Initial)

Social Security Number*: _____ Date of Birth: _____

Address *(if different from patient's)*: _____

Home Phone *(if different from patient's):* _____Cell: _____

Work Phone: _____ Email: _____

Occupation: _____ Employer: _____

Name of Dental Insurance Company: _____ *(Please give dental card to receptionist to copy for file.)*

*For insurance purposes.

PERSON RESPONSIBLE OF ACCOUNT

Check one: ( ) Parents ( ) Split Bill Between Parents ( ) Father Only ( ) Mother Only ( ) Guardian

AUTHORIZATION

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment. I acknowledge that I have had an opportunity to review the office privacy notice and I am in agreement with the office privacy practices.

I consent to the disclosure of my records, treatment information, appointments, etc. (or my child's) to the following persons who are involved in my care (or my child's care) or payment for that care (i.e. step-parent, grand-parent). My consent to disclosure of records shall be effective until I revoke it in writing.

_____ _____ _____ _____
Print Name **Relationship to Patient** **Print Name** **Relationship to Patient**

I hereby authorize payment of the orthodontic insurance benefits to be made directly to Kittleson Orthodontics S.C. I understand that I am responsible for all costs of diagnosis and treatment not paid by the insurance company. I hereby authorize the orthodontic office to administer and perform such diagnostic and treatment procedures as may be necessary for proper orthodontic care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

X_____ Date:_____
( ) Father ( ) Mother ( ) Guardian

HEALTH HISTORY and PATIENT INFORMATION

Your careful and complete answers to the following questions will be very helpful in the evaluation of your orthodontic problem.

PATIENT'S NAME: _____ **DATE**: _____
Child's physician: _____ Address: _____
Date of last medical examination: _____ Results: _____
Height: _____ Weight: _____ Present Health? Good _____ Fair _____ Poor _____
Has patient any history of a major illness? Yes ____ No ____
Has the patient been under the care of a physician during the past two years other than for routine examination? Yes ____ No ____

Check any of the following for which the patient has been treated:

Diabetes	___	Heart problems	___	Bone disorders	___
Hepatitis	___	Bleeding disorders	___	Joint pain	___
Anemia	___	Ear infections	___	Headaches	___
Epilepsy	___	Hormone disorders	___	Convulsions	___
Aids / HIV	___	Sinus infections	___	Dizziness	___
Allergies	___	Asthma / Hay fever	___	Arthritis	___

If you answered yes to any of these questions, please explain:_____
_____
_____

Does patient vomit, gag, or faint easily? Yes ____ No ____
Does patient have tendency for colds? ____ sore throats? ____ ear infections? ____ Yes ____ No ____
Have tonsils and adenoids been removed? What age? _____
List allergies or drug sensitivity: _____
_____
Present drugs or medications being taken: _____
Does patient have arthritis or pain in any joints of the body? Yes ____ No ____
Has the patient ever been treated for mental stress, nerves or any emotional problem ? Yes ____ No ____
How many times a week does the patient have a headache? None ____ Few ____ Many ____
How many times a week does the patient take aspirin, Tylenol or other pain medications? None ____ Few ____ Many ____

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Has the patient reached puberty? Yes ____ No ____
Approximate increase in height in the last 6 months _____ inches.

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DENTAL HISTORY

Has the patient had any injury of any type to the face, teeth, chin, or jaws? Yes ____ No ____
Give details of any injuries: _____
_____
Has the patient been involved in any automobile, bike, skateboard, swimming pool, or any other sporting accident? Yes ____ No ____
Give details of any injuries: _____
_____
Has patient ever had any pain in the jaw joints? Yes ____ No ____
Has patient ever had any clicking or popping sounds from the jaw joints? Yes ____ No ____
Has patient ever had a time when the jaw couldn't open or close? Yes ____ No ____
Has the patient had any muscle pain, tiredness or stiffness of the jaw or neck? Yes ____ No ____
Does the patient grind or clench teeth? Yes ____ No ____
While awake? _____ While asleep? _____
Has the patient had any problems with sore or bleeding gums? Yes ____ No ____
Does the patient play a musical instrument? Yes ____ No ____
Are there any parts of the mouth or any teeth that are sore to pressure or irritants? (cold, hot, sweets, biting hard foods etc.) Yes ____ No ____
Has the patient had any unusual dental experiences? Yes ____ No ____
Specify: _____
Are there any medical, dental or surgical problems not covered above? Yes ____ No ____
Specify: _____

(PLEASE COMPLETE THE OTHER SIDE)

The following are some habits of interest to the orthodontist. List information as it pertains to the patient.

Thumb sucking until age ____ years Tongue thrusting Yes ____ No ____
Finger sucking until age ____ years Mouth breathing Yes ____ No ____
Lip-biting or lip sucking Yes ____ No ____ Nail biting Yes ____ N0 ____
Other habits Yes ____ No ____ Please explain: _____

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PATIENT'S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:

What are the patient's or parent's main concerns regarding the jaws and teeth?

Crowding	___	Deep bite	___	"Buck teeth"	___	Receding jaw	___
Spaces	___	Open bite	___	"Under bite"	___	Prominent jaw	___
Neck pain	___	Gum disease	___	Clicking jaw	___	Headaches	___
Jaw pain	___	Gummy smile	___	Missing teeth	___	Face proportions	___
Shape of teeth	___	Habits	___	Others	_____		

Orthodontic consultation prompted by:
Dentist ___ Patient ___ Mother ___ Father ___
Physician ___ Friend ___ Sibling ___ Spouse ___
Other (specify) _____

Patient's interest in orthodontic problem and braces:
Wants treatment ___ Treatment if necessary ___
Unwilling but agrees ___ Uncooperative ___

Was patient aware of any orthodontic problem? Yes ____ No ____

Patient brushes teeth:
Several times a day ___ Nearly every day ___ Rarely ___
Once a day ___ Occasionally ___ Never ___

Dental check-ups:
Twice a year ___ Once a year ___ Only if urgent ___ Never ___

Date of last dental check-up: _____ By whom? _____ Next visit? _____

Has the patient ever been placed on an oral hygiene program by the dentist? Yes ____ No ____
Has the patient had deciduous (baby) teeth or permanent teeth removed or extracted? Yes ____ No ____
Are there other family members with a similar condition? Yes ____ No ____
Mother ____ Father ____ Sister ____ Brother ____
Has anyone in the family had orthodontic treatment? Yes ____ No ____
Mother ____ Father ____ Sister ____ Brother ____
Has the patient had a previous orthodontic consultation and / or treatment? Yes ____ No ____
When: _____ By whom: _____
What school subjects does the patient like best? _____
_____
Does the patient like school? Yes ____ No ____
What are the patient's favorite hobbies, sports, or pastimes? _____
_____
By what name does the patient prefer to be called? _____
Are you aware that appointments will infringe on school time? Yes ____ No ____
Do you wish to talk to the orthodontist privately about any problem? Yes ____ No ____
Signature of individual completing this form: _____
Relationship to patient: _____

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MEDICAL UPDATES:

I have read the MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions**.**

Date:	Exceptions		Signature
_____	_____	None [ ]	_____
_____	_____	None [ ]	_____
_____	_____	None [ ]	_____
_____	_____	None [ ]	_____

Reviewed by: _____ *Date:* _____