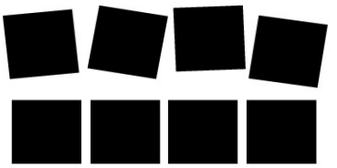

REDMOND ORTHODONTICS

ORTHODONTIC (CHILD) INFORMATION SHEET

Patients Number: Age: Birthdate:

Patients Name: Nickname: Gender:

Home Address:

Street ***City*** ***State*** ***Zip Code***

Home Phone: School: Grade:

FINANCIAL INFORMATION

Person Responsible for Account: Relationship to Patient:

Telephone: E-Mail:

(To be used to access/confirm appointment)

Billing Address:

Street ***City*** ***State*** ***Zip Code***

(Primary Dental Insurance)

Name of Insured: Employer:

Name of Insurance Company: Insurance Company Phone:

Birthdate: Social Security #: Group#:

(Secondary Dental Insurance)

Name of Insured: Employer:

Name of Insurance Company: Insurance Company Phone:

Birthdate: Social Security #: Group#:

FAMILY STATUS

Father's Name: Cell#:

Mother's Name: Cell#:

Siblings: # of sister(s) # of brother(s)

Patient lives with? Mom ☐ Dad ☐ Other

Have we treated any family members? Who?

Family Dentist: Last Visit:

Family Physician: Last Visit:

Who may we thank for referring you?

Reason for seeking Orthodontic Care:

Please check ***yes*** or ***no*** to all of the following questions. The answers are for the office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation. Do you have or have you had any of the following?

Medical History

Birth defects or hereditary problems	y ☐	n ☐
Bone fractures, any major accidents	y ☐	n ☐
Rheumatoid or arthritic conditions	y ☐	n ☐
Endocrine or thyroid conditions	y ☐	n ☐
Kidney problems	y ☐	n ☐
Diabetes	y ☐	n ☐
Cancer or been treated for a tumor	y ☐	n ☐
Stomach ulcer or hyperacidity	y ☐	n ☐
Polio, mononucleosis, tuberculosis, Or pneumonia	y ☐	n ☐
Problems of the immune system	y ☐	n ☐
Hepatitis, Jaundice or liver problem	y ☐	n ☐
Fainting spells, seizures, epilepsy or Neurologic disease	y ☐	n ☐
Mental health or behavior problems	y ☐	n ☐
Vision, hearing, tasting or speech Difficulties	y ☐	n ☐
Excessive bleeding, anemia or bleeding tendency	y ☐	n ☐
High or low blood pressure	y ☐	n ☐
Easily tired	y ☐	n ☐
Chest pain, shortness of breath or Swollen ankles	y ☐	n ☐
Cardiovascular (Heart) problems	y ☐	n ☐
Skin disorder	y ☐	n ☐
Do you have a normal/good diet	y ☐	n ☐
Frequent headaches/colds/sore throat	y ☐	n ☐
Any history of speech problems	y ☐	n ☐
Eye, ear, nose throat condition	y ☐	n ☐
Hayfever, asthma, sinus trouble, hives	y ☐	n ☐
Tonsils or adenoid conditions	y ☐	n ☐
Tonsils removed	y ☐	n ☐
Allergies or drug reactions	y ☐	n ☐
Have you ever used fen-Phen	y ☐	n ☐

If yes, how long? _____

Are you taking medication, nutrient supplements, or
Non-prescription medicine y ☐ n ☐

If yes, please name them _____
_____
_____

Are you in good physical health y ☐ n ☐

Date of last physical exam _____

Dental History

Chipped/injured baby or permanent teeth	y ☐	n ☐
Jaw fractures, cysts, mouth infections	y ☐	n ☐
Root canals treated	y ☐	n ☐
Periodontal (Gum) disease	y ☐	n ☐
Frequent canker sores or cold sores	y ☐	n ☐
Thumb or finger sucking habit	y ☐	n ☐

If yes, until age _____

Abnormal swallowing habit (tongue thrust)	y ☐	n ☐
Mouth breathing habit, snoring, difficulty in Breathing	y ☐	n ☐
Tooth grinding, jaw clenching, jaw clicking Or locking	y ☐	n ☐
Do you have or experience any pain in the muscles face or around your ears	y ☐	n ☐
Any pain in the jaws or ringing in the ears	y ☐	n ☐
Difficulty encountered in chewing or Jaw opening	y ☐	n ☐
History of supernumerary (extra) or congenitally Missing teeth	y ☐	n ☐
Have any permanent teeth been removed	y ☐	n ☐
Any teeth irritating cheek, lips, tongue or Your palate (roof of mouth)	y ☐	n ☐
Have you ever had orthodontic treatment	y ☐	n ☐
Worn a bite plate or retainer	y ☐	n ☐
Have you recently been under another dentist's Care	y ☐	n ☐

Specialist _____

Allergic to latex (gloves)	y ☐	n ☐
Concerned about spaced crooked or Protruding teeth	y ☐	n ☐
Aware/concerned about over/under developed Jaw	y ☐	n ☐
Any relative with similar tooth or jaw relationships	y ☐	n ☐
Any wisdom tooth problems	y ☐	n ☐
Have you had a bad dental experience	y ☐	n ☐

How often do you brush? _____

How often do you floss? _____

Realizing that successful treatment greatly depends upon the patients complete cooperation in the following instructions, keeping appointments, and maintaining good oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? _____
_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his Staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to my medical or dental status, I will so inform this practice.

Signature of Patient/Guardian _____ **Date** _____

Signature of Doctor _____ **Date** _____