

WELCOME TO OUR OFFICE

PATIENT'S NAME _____ NICKNAME _____ SEX: M ___ F ___

HOME ADDRESS _____ CITY _____ ZIP CODE _____

AGE _____ BIRTHDATE _____ HOME PHONE _____

PARENTS ARE: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

FATHER'S NAME _____ OCCUPATION _____

Employer _____ Business Phone _____

MOTHER'S NAME _____ OCCUPATION _____

Employer _____ Business Phone _____

PERSON RESPONSIBLE FOR ACCOUNT _____

BRIEFLY DESCRIBE THE ORTHODONTIC PROBLEM _____

Describe any previous orthodontic treatment/consultation: _____

Indicate the concern for orthodontic treatment:

Parents are: very concerned _____ concerned _____ indifferent _____ opposed _____

Patient is: very concerned _____ concerned _____ indifferent _____ opposed _____

Which family member(s) has similar dental or facial problems? _____

Which family member(s) received orthodontic treatment? _____

NAME/AGE of BROTHER(S), SISTER(S) _____

INSURANCE PLAN WHICH MAY COVER ORTHODONTIC TREATMENT _____

MEMBERSHIP NUMBER _____ GROUP NUMBER _____

SUBSCRIBER'S NAME _____

SUBSCRIBER'S IDENTIFICATION NUMBER AND BIRTHDATE _____ -- _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

FAMILY PHYSICIAN _____ Approximate Date of Last Exam _____

PATIENT'S GENERAL HEALTH IS: excellent _____ good _____ fair _____ poor _____

Is patient under any medical treatment now? _____

Present Height (*approximate*) _____ Present Weight (*approximate*) _____

Absences per School Year _____ Main Reason(s) for Absences _____

FAMILY DENTIST _____ Approximate Date of Last Exam _____

ORAL HEALTH IS: good _____ fair _____ poor _____ DOES PATIENT FLOSS DAILY? _____

DOES PATIENT HAVE ANY OF THE FOLLOWING HABITS? (*check all that apply*)

_____ Finger/Thumb Habit _____ Lip/Cheek Biting

_____ Grinding Teeth _____ Clenching Teeth

_____ Mouth Breathing _____ Tongue Thrusting

PATIENT'S INTERESTS and HOBBIES _____

SCHOOL ATTENDING _____ Present Grade Level (*in summer, list grade entering in Fall*) _____

(PLEASE CONTINUE TO SECOND PAGE)

**DR. LILI K. HORTON
ORTHODONTIST**

PATIENT- PAST AND PRESENT MEDICAL HISTORY:

YES NO

- () () Have tonsils/adenoids been removed? *If yes, age of surgery:* _____
- () () Allergy to: PENICILLIN _____, ASPIRIN _____, Other Drugs _____, METALS (Nickel, Chromium/etc.) _____, LATEX (Rubber products) _____
- () () Other allergies: Asthma _____, Hayfever _____, Hives _____, Skin Rash _____, Other _____
- () () Frequent nasal obstruction _____, Earaches _____, Sore Throat _____
- () () Any accidents/trauma to face or teeth? ACCIDENT DATE _____
If yes, please describe: _____
- () () Frequent headaches _____, Jaw Pain _____, Jaw noise _____
- () () Speech problem *If yes, please describe:* _____
- () () Significant increase in height (*past six months to one year*)

DOES PATIENT HAVE OR HAS PATIENT HAD ANY OF THE FOLLOWING?

IF NO, PLEASE CHECK HERE _____.

IF YES, PLEASE CHECK ALL THAT APPLY.

- | | |
|--|----------------------------------|
| _____ Anemia | _____ Rheumatic Fever |
| _____ Bleeding Problems | _____ Rheumatic Heart Disease |
| _____ Diabetes | _____ Eye Problems |
| _____ Strep Throat | _____ Ear/Hearing Problems |
| _____ Respiratory Disease | _____ Stomach/Intestinal Disease |
| _____ Cold sores/Canker sores/Herpes | _____ Cancer |
| _____ Fainting/Epilepsy/Seizures | _____ Liver Disease/Jaundice |
| _____ Emotional Disorders | _____ Hepatitis |
| _____ Kidney Disease | _____ Tuberculosis (TB) |
| _____ Arthritis | _____ HIV/AIDS |
| _____ Bone Disease | _____ Venereal Disease (VD) |
| _____ Thyroid Problems | _____ Other Infectious Disease |
| _____ High/Low Blood Pressure <i>If yes, is it controlled?</i> _____ | |
| _____ Heart Problems <i>If yes, please explain:</i> _____ | |

DOES PATIENT HAVE ANY DISEASE OR CONDITION NOT LISTED ABOVE THAT WE SHOULD KNOW ABOUT?

IF NO, PLEASE CHECK HERE _____.

IF YES, PLEASE EXPLAIN: _____

FOR FEMALE PATIENT: Has menstruation begun? *If yes, year started:* _____

PARENT'S SIGNATURE _____ DATE _____