Schantz & Moranda
Orthodontic Care
A Dental Corporation

CHILD Confidential Patient Information

Date _____

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

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

Confidential Responsible Party Information

A B C

Name _____ (Last) _____ (First) _____ (Middle) Marital Status _____

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____ (Street) _____ (City) _____ (State) _____ (Zip)

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ (Last) _____ (First) _____ (Middle) Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No ☐ Yes ☐ If yes: _____

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

GIRLS ONLY

☐ yes ☐ no ☐ dk/u Has the patient started her monthly periods?

If so, approximately when?_____

☐ yes ☐ no ☐ dk/u Is the patient pregnant?

FAMILY MEDICAL HISTORY

Do your parents or siblings have, or have ever had any of the following health problems? If so, please explain:

Bleeding disorders_____

Diabetes_____

Arthritis_____

Severe allergies_____

Unusual dental problems_____

Jaw size imbalance_____

Any other family medical conditions that we should know about?

_____

DENTAL HISTORY

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Started teething very early or late?

☐ yes ☐ no ☐ dk/u Primary (baby) teeth removed that were not loose?

☐ yes ☐ no ☐ dk/u Permanent or "extra" (supernumerary) teeth removed?

☐ yes ☐ no ☐ dk/u Supernumerary (extra) or congenitally missing teeth?

☐ yes ☐ no ☐ dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

☐ yes ☐ no ☐ dk/u Teeth sensitive to hot or cold; teeth throb or ache?

☐ yes ☐ no ☐ dk/u Jaw fractures, cysts or mouth infections?

☐ yes ☐ no ☐ dk/u "Dead teeth" or root canals treated?

☐ yes ☐ no ☐ dk/u Bleeding gums, bad taste or mouth odor?

☐ yes ☐ no ☐ dk/u Periodontal "gum problems"?

☐ yes ☐ no ☐ dk/u Food impaction between teeth?

☐ yes ☐ no ☐ dk/u Thumb, finger, or sucking habit? Until what age_____?

☐ yes ☐ no ☐ dk/u Abnormal swallowing habit (tongue thrusting)?

☐ yes ☐ no ☐ dk/u History of speech problems?

☐ yes ☐ no ☐ dk/u Mouth breathing habit, snoring or difficulty in breathing?

☐ yes ☐ no ☐ dk/u Tooth grinding or jaw clenching?

☐ yes ☐ no ☐ dk/u Any pain, clicking or locking in jaw or ringing in the ears?

☐ yes ☐ no ☐ dk/u Any pain or soreness in the muscles of the face or around the ears?

☐ yes ☐ no ☐ dk/u Difficulty encountered in chewing or jaw opening?

☐ yes ☐ no ☐ dk/u Aware of loose, broken or missing restorations (fillings)?

☐ yes ☐ no ☐ dk/u Any teeth irritating cheek, lip, tongue or palate?

☐ yes ☐ no ☐ dk/u Aware or concerned about spaced, crooked or protruding teeth?

☐ yes ☐ no ☐ dk/u Aware or concerned about under or over developed jaw?

☐ yes ☐ no ☐ dk/u "Gum boils," frequent canker sores or cold sores?

☐ yes ☐ no ☐ dk/u Taking any forms of fluoride?

☐ yes ☐ no ☐ dk/u Any relative with similar tooth or jaw relationships?

☐ yes ☐ no ☐ dk/u Had periodontal (gum) treatment?

☐ yes ☐ no ☐ dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

☐ yes ☐ no ☐ dk/u Any serious trouble associated with any previous dental treatment?

☐ yes ☐ no ☐ dk/u Ever had a prior orthodontic examination or treatment?

☐ yes ☐ no ☐ dk/u Been under another dentist's care?

Specialist_____

Other_____

How often does your child brush:_____ Floss:_____

What is your primary concern? Why are you here?_____

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

Signed:_____ Date Signed:_____
(Parent or Guardian)

Signed:_____ Date Signed:_____
(Dental staff member)

For the following questions, mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

☐ yes ☐ no ☐ dk/u Does patient follow directions well?

☐ yes ☐ no ☐ dk/u Does patient brush his/her teeth conscientiously?

☐ yes ☐ no ☐ dk/u Does patient have learning disabilities or need extra help with instructions?

☐ yes ☐ no ☐ dk/u Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Birth defects or hereditary problems?

☐ yes ☐ no ☐ dk/u Bone fractures, any major accidents?

☐ yes ☐ no ☐ dk/u Rheumatoid or arthritic conditions?

☐ yes ☐ no ☐ dk/u Endocrine or thyroid problems?

☐ yes ☐ no ☐ dk/u Kidney problems?

☐ yes ☐ no ☐ dk/u Diabetes?

☐ yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?

☐ yes ☐ no ☐ dk/u Stomach ulcer or hyperacidity?

☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?

☐ yes ☐ no ☐ dk/u Problems with the immune system?

☐ yes ☐ no ☐ dk/u AIDS or HIV positive?

☐ yes ☐ no ☐ dk/u Hepatitis, jaundice or liver problems?

☐ yes ☐ no ☐ dk/u Fainting spells, seizures, epilepsy or neurological problem?

☐ yes ☐ no ☐ dk/u Mental health disturbance or depression?

☐ yes ☐ no ☐ dk/u Vision, hearing, tasting or speech difficulties?

☐ yes ☐ no ☐ dk/u Loss of weight recently, poor appetite?

☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?

☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?

☐ yes ☐ no ☐ dk/u High or low blood pressure?

☐ yes ☐ no ☐ dk/u Tired easily?

☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath or swelling ankles?

☐ yes ☐ no ☐ dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

☐ yes ☐ no ☐ dk/u Skin disorder?

☐ yes ☐ no ☐ dk/u Does the patient eat a well-balanced diet?

☐ yes ☐ no ☐ dk/u Frequent headaches, colds or sore throats?

☐ yes ☐ no ☐ dk/u Eye, ear, nose or throat condition?

☐ yes ☐ no ☐ dk/u Hayfever, asthma, sinus trouble or hives?

☐ yes ☐ no ☐ dk/u Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

☐ yes ☐ no ☐ dk/u Local anesthetics (Novocaine or Lidocaine)

☐ yes ☐ no ☐ dk/u Aspirin

☐ yes ☐ no ☐ dk/u Ibuoprofen (Motrin, Advil)

☐ yes ☐ no ☐ dk/u Penicillin or other antibiotics

☐ yes ☐ no ☐ dk/u Sulfa drugs

☐ yes ☐ no ☐ dk/u Codeine or other narcotics

☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)

☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)

☐ yes ☐ no ☐ dk/u Vinyl

☐ yes ☐ no ☐ dk/u Acrylic

☐ yes ☐ no ☐ dk/u Animals

☐ yes ☐ no ☐ dk/u Foods (specify)_____

☐ yes ☐ no ☐ dk/u Other substances (specify)_____

_____

☐ yes ☐ no ☐ dk/u Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them:

Medication_____ Taken for_____

Medication_____ Taken for_____

Medication_____ Taken for_____

Medication_____ Taken for_____

☐ yes ☐ no ☐ dk/u Does the patient currently have or ever had a substance abuse problem?

☐ yes ☐ no ☐ dk/u Does the patient chew or smoke tobacco?

☐ yes ☐ no ☐ dk/u Operations? Describe:_____

_____

☐ yes ☐ no ☐ dk/u Hospitalized? Describe:_____

_____

☐ yes ☐ no ☐ dk/u Other physical problems or symptoms?

Describe:_____

_____

_____

☐ yes ☐ no ☐ dk/u Being treated by another health care professional?

For:_____

Date of most recent physical exam?_____

Do you have any other medical conditions that we should know about?

_____