MANHATTAN EASTSIDE
ORTHODONTICS

PATIENT INFORMATION **Date:** _____

Patient's name:_____

Last First Middle

Address: _____

Street City Zip

Birthdate:_____ Age:_____ Sex:_____Preferred name:_

Home Phone: _____Cell Phone: _____

School: _____ Grade: _____ Email address:_____

Hobbies/Sports: _____

Please list children in the family (name and ages): _____

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

FAMILY INFORMATION

Father's Name:_____ Occupation: _____

Employer: _____

Mother's Name:_____ Occupation:_____

Employer: _____

Parents' Marital Status: Married Divorced Separated Widowed Not married

Patient Living with: Mother Father Other: _____

RESPONSIBLE PARTY INFORMATION

Name: _____

Last First Middle

Address: _____

Street City, State
Zip
Birthdate: _____
Home phone: _____ Work phone: _____
__
Cell Phone: _____
Email address: _____
__
Where do you prefer to be contacted? _____
___

DENTAL INSURANCE INFORMATION
Insured's Name: _____

Insurance Company: _____ Group No:_____ ID No.:_____
__
Name of Patient's Dentist: _____ Phone Number: _____
Address: _____

Name of patient's Physician: _____ Phone Number: _____
Address: _____

MEDICAL HISTORY
Please describe any major illnesses or hospitalizations: _____
_____
_____
Is the patient taking any medications? _____
_____ Has the patient been under the care of a physician during the past 3 years, other than for routine examination (please explain)? _____
_____

Has the patient ever had (please circle):

Abnormal blood pressure	Diabetes	Heart Valve Condition
Abnormal bleeding	Dizziness	Hepatitis
ADD/ADHD	Eating Disorders	HIV Positive Status
Anemia	Emotional Disorders	Kidney Disease
Arthritis	Endocrine Disorder	Oral Ulcers
Asthma	Epilepsy/and/or Seizures	Rheumatic Fever
Autism	Headaches/Migraines	Sleep Disturbances
Autoimmune disorder	Head or Face injury	Speech Difficulties
Blood/bone disorder	Hearing Impairment	Surgery
Cancer	Hear Disease	Thyroid Condition

Cold sores Heart Murmur Tuberculosis
Other (please describe): _____
_____
Does the patient have any allergies? _____
_____Does the patient require premedication prior to dental treatment?
_____Has the patient reached puberty (menstruation, voice change)? Yes No How long ago?_____

DENTAL HISTORY
Date of last dental visit:_____
_____
Were the patient's teeth cleaned at that visit? **Yes No**
How often does the patient brush his/her teeth? _____
Is there a history of trauma to any teeth? **Yes No**
If so, please explain: _____
_____ Has the patient ever sucked his/her thumb or fingers? **Yes No**
Is there a history of lip biting or lip sucking? **Yes No**
Is there a history of nail biting? **Yes No**
Is there a history of clenching or grinding the teeth? **Yes No**
Is there a history of pain or clicking/popping in or around the ear or jaw joint (TMJ)? **Yes No**
Is there a tongue thrust habit or other functional problem? **Yes No**
Are there frequent sore throats or a history of tonsillitis? **Yes No**
Is there a history of mouth breathing or snoring? **Yes No**
Does the patient experience difficulty or pain when chewing? **Yes No**
Has the patient ever had an Orthodontic evaluation? **Yes No**
If yes, when and by whom? _____

What is the patient's or parent's primary concern? What brings you to the office today?_____
_____
What is expected from orthodontic treatment? _____
_____

What is the patient's interest in orthodontic treatment?
Wants treatment Only if necessary Unwilling, but will cooperate Uncooperative

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

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my

responsibility to inform this office of any changes in my child's medical status.

_____

Signature of parent/guardian/patient **Date**