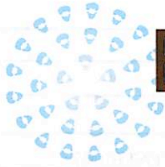

Brookhaven ORTHODONTICS

CHILD

PATIENT INFORMATION

DATE ______________ AGE ____________

PATIENT'S NAME ____

LAST FIRST MIDDLE PREFERRED NAME

HOME ADDRESS ____

(ZIP CODE)

BIRTH DATE ______________ SEX ________ HOME PHONE ________________________

WHOM MAY WE THANK FOR RECOMMENDING OUR SERVICES? ________________________

NAMES AND AGES OF CHILDREN IN FAMILY HAVE ANY BEEN SEEN IN OUR OFFICE? YES NO

________________________ _____ ________________________ _____

________________________ _____ ________________________ _____

RESPONSIBLE PARTY INFORMATION

NAME ____

LAST FIRST MIDDLE MARITAL STATUS

HOME ADDRESS ____

(IF DIFFERENT THAN ABOVE) (ZIP CODE)

HOME PHONE ________________ CELL PHONE ________________ WORK PHONE ________________

SOCIAL SECURITY # ________________ BIRTH DATE ________________ RELATIONSHIP TO PATIENT ________

EMPLOYER ________________ OCCUPATION ________________ NUMBER OF YEARS EMPLOYED ________

SPOUSE'S NAME ________________________ RELATIONSHIP TO PATIENT ________

EMPLOYER ________________ OCCUPATION ________________ NUMBER OF YEARS EMPLOYED ________

BIRTH DATE ____________ WORK PHONE ________________ CELL PHONE ________________

RESPONSIBLE PARTY EMAIL FOR APPOINTMENT REMINDERS, ETC. ________________________

DENTAL INSURANCE

PRIMARY INSURANCE: *(IF INSURED'S ADDRESS IS DIFFERENT THAN RESPONSIBLE PARTY, PLEASE INFORM OUR OFFICE)*

INSURED'S FULL NAME ________________________ BIRTH DATE ____________

SOCIAL SECURITY # ________________ RELATIONSHIP TO PATIENT ________________

INSURANCE COMPANY ________________________ PHONE # ________________

GROUP # ________________ DOES POLICY HAVE ORTHODONTIC BENEFITS? YES NO DON'T KNOW

MEMBER ID # ________________ INSURED'S EMPLOYER ________________________

SECONDARY INSURANCE: *(IF INSURED'S ADDRESS IS DIFFERENT THAN RESPONSIBLE PARTY, PLEASE INFORM OUR OFFICE)*

INSURED'S FULL NAME ________________________ BIRTH DATE ____________

SOCIAL SECURITY # ________________ RELATIONSHIP TO PATIENT ________________

INSURANCE COMPANY ________________________ PHONE # ________________

GROUP # ________________ DOES POLICY HAVE ORTHODONTIC BENEFITS? YES NO DON'T KNOW

MEMBER ID # ________________ INSURED'S EMPLOYER ________________________

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE (NOT LIVING WITH YOU) ________________________

PHONE NUMBER (S) ________________________ RELATIONSHIP TO PATIENT ________________

GENERAL INFORMATION

WHAT CONCERNS YOU ABOUT YOUR TEETH AND JAWS? ______

OTHER FAMILY MEMBERS WITH SIMILAR CONDITION? ______

WHO SUGGESTED THAT YOU MIGHT NEED ORTHODONTIC TREATMENT? ______

HAS THE PATIENT EVER HAD ANY PREVIOUS ORTHODONTIC TREATMENT OR CONSULTATION? ______

WHY DID YOU SELECT OUR OFFICE? ______

LIST INTERESTS AND HOBBIES ______

WHAT SCHOOL DOES THE PATIENT ATTEND? ______ GRADE? ______

DENTAL HISTORY

PATIENT'S DENTIST ______ REASON FOR LAST VISIT ______

HOW OFTEN DOES THE PATIENT HAVE DENTAL CHECK-UPS? ______

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? ______

DOES THE PATIENT HAVE ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR EARS? ______

HAS THE PATIENT BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? ______

DOES THE PATIENT CLENCH OR GRIND HIS/HER TEETH? ______

MEDICAL HISTORY

PATIENT'S PHYSICIAN ______ ADDRESS ______

PHYSICIAN'S PHONE NUMBER ______ DATE OF MOST RECENT PHYSICAL EXAM ______

HAS THE PATIENT EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
DIABETES	___	___	TUBERCULOSIS	___	___	ENDOCRINE OR THYROID	___	___
ASTHMA	___	___	ANEMIA	___	___	PROLONGED BLEEDING	___	___
CANCER	___	___	EPILEPSY	___	___	LIVER INVOLVEMENT	___	___
RHEUMATIC FEVER	___	___	HIV/AIDS	___	___	FAINTING OR DIZZINESS	___	___
BONE DISORDERS	___	___	HEPATITIS	___	___	NERVOUS DISORDERS	___	___
SLEEP APNEA	___	___	HEART DISEASE	___	___	KIDNEY INVOLVEMENT	___	___

IS THE PATIENT IN GOOD HEALTH? ______

IS IT NECESSARY FOR THE PATIENT TO PRE-MEDICATE PRIOR TO DENTAL VISITS? ______

DOES THE PATIENT TAKE ANY BISPHOSPHONATE MEDICATIONS FOR BONE DISORDERS, SUCH AS FOSAMAX ______

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN AND GIVE REASONS ______

______

LIST ANY ALLERGIES OR DRUG SENSITIVITY ______

ANY MEDICAL, DENTAL, OR SURGICAL PROBLEMS NOT COVERED ABOVE? ______

______

To the best of my knowledge, the 2 pages of information (front and back) is complete and correct. I give permission for any photographs, x-rays, or study models to be used for displays at scientific presentations and/or publications of a scientific nature or for group purposes to further the art and science of orthodontics. 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. I will notify my orthodontist of any changes in my medical or dental health. Also, I understand that where appropriate, credit bureau reports may be obtained.

______ Date

______ Signature of Patient or Parent or Guardian if Patient is a Minor