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CURTIS ORTHODONTICS

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Member
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PATIENT INFOMATION
(Child/Adolescent)

PATIENT NAME: _____ DATE: _____/_____/ 20_____
BIRTH DATE: _____ SEX: F or M
ADDRESS: _____CITY:___ _____ ZIP:_____Home Phone: (___)____-_____
EMAIL / TEXT MSG (appointment reminders): _____@ _____
FATHER: _____ Occupation:_____
Employer:_____ Father Phone (Work or Mobile): (___)____-_____
MOTHER: _____ Occupation: _____
Employer:_____ Mother Phone (Work or Mobile): (___)____-_____
Do patient, mother & father live together? _____
Name of your child's physician: _____Date of Last Visit: _____
Name of your child's dentist: _____Date of Last Visit:_____
Billing party _____
Do you have orthodontic insurance benefits? Yes No Don't Know
Primary Dental Insurance _____Phone: (___)____-_____
Insured Person _____
SSN _____-_____-_____ DOB_____/_____/_____
Insurance ID#_____ Group#_____

MEDICAL HISTORY

1. Is your child in good health? …… Yes No Don't Know
2. Does your child have a health problem? …….. Yes No Don't Know
   If yes, explain: _____
   _____
3. Has your child ever been hospitalized, had general anesthesia, or emergency room visits?
   Yes No Don't Know
   If yes, explain: _____
4. Are your child's immunizations up to date? …….. Yes No Don't Know
5. Does your child have allergies to medications (drugs), medical products (latex), or the environment (dust, mites, pollen, and mold)? ..... Yes No Don't Know
   If yes, please list: _____
6. List past medications taken by child: _____
7. List daily medications child is now taking: _____

8. Has your child ever had or been treated by a physician for:

Check one for each condition

Yes	No	?		Yes	No	?	
			a. Problems at birth				p. Cancer
			b. Heart Murmur				q. Cerebral palsy
			c. Heart disease				r. Seizures
			d. Rheumatic fever				s. Asthma
			e. Anemia				t. Cleft lip/palate
			f. Sickle cell anemia				u. Speech or hearing problems
			g. Bleeding/hemophilia				v. Eye problems/contact lenses
			h. Blood transfusion				w. Skin problems
			i. Hepatitis				x. Tonsil/adenoid/sinus problems
			j. AIDS or HIV+				y. Sleep Problems
			k. Tuberculosis				z. Emotional/behavior problems
			l. Liver disease				aa. Radiation therapy
			m. Kidney disease				bb. Growth problems
			n. Diabetes				cc. Attention deficit disorders
			o. Arthritis				dd.

9. Has your child had any recent rapid growth? _____ If so, how much? _____
10. Parents: (Father) Ht: ____ Wt: ____ (Mother) Ht: ____ Wt: _____
11. Older brothers and sisters: (1) Ht: ___ Wt: ___ (2) Ht:____ Wt: ____ (3) Ht:____ Wt: ____
12. Females: Has menstruation begun? ____ If yes, when? _____ Pregnant? _____
13. If yes to any above, please explain this or any other problem: _____

_____

14. Child's grade in school: _____ Child's school: _____
15. Do you consider your child to be (check one):

Advanced in learning Progressing normally Slow learner

16. What is your main concern about your child's dental condition? _____
17. Has your child been to a dentist before? No Yes

DENTAL HISTORY

18. Check for each condition:

Yes	No	?	
			a. Has your child ever had dental x-rays? Date of last x-rays? _____
			b. Will your child be uncooperative? If yes, explain: _____
			c. Has your child experienced any complications following dental treatment? If yes, explain: _____
			d. Has your child had cavities and / or toothaches/
			e. Are your child's teeth sensitive to temperature or food?
			f. Did you or your child ever get instructions in brushing?
			g. Do your child's gums bleed when brushed?
			h. Does your child use fluoride products; rinses, drops, tabs?
			i. Does or has your child had any clicking or pain in the jaw joint?
			j. Does or has your child had any problems opening or closing their mouth?
			k. Has your child inherited any family facial or dental characteristics? If yes, explain: _____
			l. Has your child ever injured his/her teeth?
			m. Has your child ever injured his/her jaws or face?
			n. Does or did your child use a pacifier?
			o. Does or did your child suck his/her fingers or thumb?

19. Does your child have any other dental problems we should know about? No Yes

Please explain: _____

20. Whom may we thank for referring you to our office? _____
21. PERSON COMPLETING THIS FORM: _____

Patient Name: _____ Date: _____

(Children)

Are you interested in: (Please indicate all that apply)

- ☐ Information
- ☐ Treatment at this time
- ☐ Clarification of previously received or conflicting information

If your child's teeth were to be changed, how would you like them change?

- ☐ Upper teeth Forward/Backward
- ☐ Lower teeth Forward/Backward
- ☐ Upper teeth up because gums show too much
- ☐ Close spaces Upper/Lower
- ☐ Straighten crowded teeth Upper/Lower

Do you realize that growth has a strong influence on the success of orthodontic treatment?

Yes No (Circle One)

Is it likely that your son or daughter will be an early maturer or late maturer?

Yes No (Circle One)

How tall do you think this child will be when growth is completed? _____ft _____inches

Are you aware that orthodontic treatment can to some extent alter facial appearance?

Yes No (Circle One)

If any features of the face could be changed, what would you like to see:

- ☐ Upper lip Forward/ Backward
- ☐ Lower lip Forward/ Backward
- ☐ Upper jaw Forward/ Backward
- ☐ Lower Jaw Forward/ Backward
- ☐ Chin Larger/ Smaller
- ☐ Nose Larger/Smaller/Different Shape

Would you prefer that facial appearance NOT be discussed in front of your child?

Yes No (Circle One)

Is there any significant family history of jaw or teeth problems?

Are you interested in improving the appearance of the teeth at this time even if more treatment will be needed later? Yes No (Circle One)

_____ _____

Signature Relationship to Patient