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_______________

E-mail:_______________

MOTHER'S NAME_______________OCCUPATION_______________

Employer_______________Business Phone_______________

E-mail:_______________

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 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 ON THE OTHER SIDE)

DR. LILI K. HORTON, D.M.D., S.M.
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, Chrominum/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________________ *If yes, please ask for our TMJ Form*
( )	( )	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
______Bleeding Problems
______Diabetes
______Strep Throat
______Respiratory Disease
______Cold sores/Canker sores/Herpes
______Fainting/Epilepsy/Seizures
______Emotional Disorders
______Kidney Disease
______Arthritis
______Bone Disease
______Thyroid Problems
______Rheumatic Fever
______Rheumatic Heart Disease
______Eye Problems
______Ear/Hearing Problems
______Stomach/Intestinal Disease
______Cancer
______Liver Disease/Jaundice
______Hepatitis
______Tuberculosis (TB)
______HIV/AIDS
______Venereal Disease (VD)
______Other Infectious Disease
______High/Low Blood Pressure *If yes, is it controlled?*______________________________
______Heart Problems *If yes, please explain:*____

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___________________________