DAVIDSON ORTHODONTICS

YOUTH PATIENT INFORMATION & HEALTH SURVEY

Welcome to our office. Please fill out information on form.

Patient's Name_____

Age_____ Birth Date_____ Sex ☐ M ☐ F

Address_____

City, State_____

Home Phone_____ Cell Phone(Adult)_____

Email (Adult)_____

School_____Grade_____

Person(s) responsible for financial matters_____

Family Dentist_____ Phone Number_____

Referred By_____

FAMILY & PATIENT INFORMATION

Father's Name_____ ☐ No ☐ Yes Living?

Occupation_____ Place of Employment_____

Mother's Name_____ ☐ No ☐ Yes Living?

Occupation_____ Place of Employment_____

Parent's Marital Status_____

Patient Living with: ☐ M ☐ F ☐ Both ☐ Other_____

Sibling(s) (name and ages)_____

Patient's interests and hobbies_____

Reason for Orthodontic Consultation?_____

_____

☐ No ☐ Yes Has anyone in your family had a similar problem?

☐ No ☐ Yes Is patient self-conscious about his/her teeth?

Patient's attitide toward orthodontic treatment?_____

_____

INSURANCE INFORMATION

☐ No ☐ Yes Are you covered by insurance for orthodontic treatment?

Insured Name_____

Insured Date of Birth_____ Insured SSN#_____

Insured Employer_____

Insurance Company_____

Insurance ID#_____ Insurance Verification Phone Number_____

Insured Claims Address_____

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MEDICAL HISTORY

Has the patient ever had any of the following?

☐ AIDS	☐ Bone Loss/Disorders	☐ Hearing Problems	☐ Lung Disease
☐ Bleeding	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Asthma
☐ Emotional Problems	☐ Herpes	☐ Thyroid Problems	☐ Endocrine Problems
☐ Hepatitis	☐ Rheumatic Fever	☐ Arthritis	☐ Head or Face Injuries
☐ Previous Surgery	☐ Anemia	☐ Diabetes	☐ Oral Ulcer
☐ Allergy	☐ Cold Sores	☐ Heart Condition	

☐ Other (please describe)_____

Comments_____

_____

☐ No ☐ Yes Has the patient been under the care of a physician during the past two years, other than for routine examinations?

Condition_____

Date of Last Medical Exam_____

☐ No ☐ Yes Do you require antibiotic premedication for dental procedures?

Present drugs or medications_____

Birth Defects_____

Patient's Height_____ Patient's Weight_____

RESPIRATORY HISTORY

Do you have:

Allergies to:

Drugs_____

Food_____

Seasonal Grasses_____

Other_____

Breathe through mouth? ☐ Seldom ☐ Sometimes ☐ Usually

☐ No ☐ Yes Snore when sleeping?

☐ No ☐ Yes Have frequent colds?

☐ No ☐ Yes Have frequent "stuffy nose?"

☐ No ☐ Yes Have frequent sore throat or tonsillitis?

☐ No ☐ Yes Have difficulty chewing or swallowing?

☐ No ☐ Yes Have you received medical treatment from an allergist or ear, nose, and throat specialist?

If yes, When_____ By whom_____

☐ No ☐ Yes Nasal Surgery ☐ No ☐ Yes Tonsils Removed ☐ No ☐ Yes Adenoids Removed

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DENTAL & TEMPOROMANDIBULAR JOINT HISTORY

☐ No ☐ Yes Have you had any unusual dental experiences?

Specify_____

☐ No ☐ Yes Any injuries to the mouth, teeth or face?

Specify_____

Date of last dental check-up_____ ☐ No ☐ Yes Were your teeth cleaned?

☐ No ☐ Yes Have you had an orthodontic consult or treatment?

☐ No ☐ Yes Do you have headaches? ☐ No ☐ Yes Neck Pain ☐ No ☐ Yes Jaw Pain

☐ No ☐ Yes Ear Pain ☐ No ☐ Yes Face Pain ☐ No ☐ Yes Eye Pain

Other_____

Which side hurts? ☐ Right ☐ Left ☐ Both

How long have you had these symptoms? Years_____ Days_____ Months_____

☐ No ☐ Yes Is the pain constant? ☐ Aching ☐ Shooting ☐ Burning ☐ Stabbing ☐ Electrical ☐ Other

☐ Worse in the afternoon? ☐ Worse in the morning? ☐ Does it hurt to chew? ☐ Does it hurt to open wide?

☐ No ☐ Yes Does your jaw ever make a popping noise? ☐ Clicking ☐ Grinding ☐ Other

☐ No ☐ Yes Has your jaw ever "locked" or slipped out of place?

☐ No ☐ Yes Do you ever clench or grind your teeth? ☐ During the day? ☐ During the night?

☐ No ☐ Yes Do you have problems with your ears? ☐ Hearing? ☐ Dizziness? ☐ Other?

☐ No ☐ Yes Is it difficult to swallow? ☐ Painful?

☐ No ☐ Yes Are the teeth sore or sensitive?

INDICATE HABITS, PAST OR PRESENT

☐ Thumb or Finger Sucking ☐ Tongue Thrust (reverse swallowing) ☐ Lip Biting ☐ Nail Biting ☐ Poor Speech Habits

☐ Other_____

Additional Comments_____

_____

_____

Responsible Party Signature_____

Date_____

Doctor Signature_____

Date_____