Deukmedjian
ORTHODONTICS

Please circle yes or no to all of the following questions. *The answers are for the office records only and will be considered confidential.* A thorough and complete history is vital to a proper orthodontic evaluation. Do you have or have you had any of the following?

Dental History Status

When was the patient last seen by the dentist?

- ☐ yes ☐ no **Does the patient need to take antibiotics or any other medications before dental treatment?**
- ☐ yes ☐ no **Has the patient had trouble associated with dental treatment?**
- ☐ yes ☐ no **Has the patient seen a periodontist, endodontist, or oral surgeon?**
- ☐ yes ☐ no **Has the patient had previous orthodontic treatment or consultation? When?**
- ☐ yes ☐ no **Has any member of the family had orthodontic treatment?**
- ☐ yes ☐ no **Has the patient had any teeth extracted? Why?**
- ☐ yes ☐ no **Has the patient ever injured or broken any teeth?**
- ☐ yes ☐ no **Does the patient have any missing or extra teeth?**
- ☐ yes ☐ no **Does the patient have any problem with eating, chewing or swallowing?**
- ☐ yes ☐ no **Does the patient suck thumb, fingers, tongue, blanket, or pacifier? (circle which)**
- ☐ yes ☐ no **Does the patient have any dental or facial pain?**
- ☐ yes ☐ no **Do the patient's jaw joints make noise or hurt when opening, closing, or chewing?**
- ☐ yes ☐ no **Does the patient habitually grind or clench teeth together?**
- ☐ yes ☐ no **Does the patient normally breathe with the lips parted?**
- ☐ yes ☐ no **Is the patient aware of any swellings or growths in the mouth or face?**
- ☐ yes ☐ no **Does the patient have any negative or resistant feelings about orthodontic treatment?**
- ☐ yes ☐ no **Is the patient especially concerned about orthodontic treatment?**
- ☐ yes ☐ no **Is the patient dissatisfied about the appearance of the teeth?**
- ☐ yes ☐ no **Is there any other information we should know?**

Medical History

Who is the patient's physician? ____________________________ **Office:** ___________________________________

When was the patient last seen by the physician? ____

- ☐ yes ☐ no **Is there a current medical problem?**
- ☐ yes ☐ no **Is the patient taking any pills, medications, or drugs?**
- ☐ yes ☐ no **Has the patient had an unusual reaction to any medication?**

Does the patient have any allergies (medicine, latex, nickel, foods)? ____

Patient's height __________ **Weight** __________

- ☐ yes ☐ no **Has the patient ever had an injury to the head, face, or mouth?**
- ☐ yes ☐ no **Has the patient had a serious illness?**
- ☐ yes ☐ no **Has the patient had any surgery or been hospitalized?**
- ☐ yes ☐ no **Are there congenital (that the patient was born with) problems?**

Has the patient ever been diagnosed or treated for the following? (Circle those that apply):

Diabetes	Liver Problem	Hepatitis	Cerebral palsy	Growth Problems
Fainting	Breathing trouble	Jaundice	Multiple sclerosis	Speech Problems
Arthritis	Prolonged bleeding	AIDS or HIV +	Sickle cell anemia	Kidney problem
Anemia	Bone disease	Asthma	Tuberculosis	Cancer

Signature of Parent/Guardian____________________________________**Date**________________

Signature of Doctor____**Date**________________

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The following information is requested so that we can communicate properly with the people involved with your child's treatment. Please fill in only if applicable. *ALL INFORMATION IS CONFIDENTIAL AND IS TREATED WITH THE UTMOST RESPECT.*

Patient Information

First ______ Last ______ E-mail ______
Address ______ DOB ______
City ______ State ______ Zip ______
Home ______ Age ______
SS# ______ Referred by ______
School ______ Hobbies ______
Dentist ______ Dentist's ______

Family Information

With whom does the patient live? ______
Who should receive routine information about treatment progress? ______

Are the parents separated? ☐ yes ☐ no Divorced? ☐ yes ☐ no Remarried? ☐ yes ☐ no

Patient's Father

Last name ______ First name ______
Home ______ SS# ______
Address ______ City ______ ST. ______ ZIP ______
Father's Occupation ______ Work ______
Name of Employer ______ Work Address ______

Patient's Mother

Last name ______ First name ______
Home ______ SS# ______
Address ______ City ______ ST. ______ ZIP ______
Mother's Occupation ______ Work ______

Name of Employer ______ Work Address ______

Other Adults We Should Know About

Last name ______ First name ______
Relationship ______
Home ______ Work ______
Last name ______ First name ______
Relationship ______
Home ______ Work ______

Patient's Siblings

Names	Ages	Schools

Insurance/Other Information

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. We will gladly assist you in submitting insurance claims pertaining to any charges for care in our office.

	Name of Insured / Name of Employer	Birth Date	Insurance Company Name
Primary			
Secondary			
Work Address			