PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

SOUTHINGTON ORTHODONTICS

Patient's Name_____DOB_____

Address_____City_____State_____Zip_____

Nickname_____School_____Sports/Hobbies_____

Parent or Guardian _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name_____DOB_____Relationship to Patient_____

Mailing Address_____City_____State_____Zip_____

Residence (if different from mailing address)_____

Cell_____Carrier_____Home_____Email_____

Employer_____Occupation_____

Spouse's Name_____DOB_____Relationship to Patient_____

Employer_____Occupation_____

Cell_____Carrier_____Home_____Email_____

DENTAL INSURANCE INFORMATION

Insured's Name_____Relationship to Patient_____SS#_____

Insurance Company_____Group #_____Subscriber ID#_____

Insurance Company Address_____Phone_____

Do you have dual coverage? Yes_____ No_____ IF YES, PLEASE FILL OUT INFORMATION BELOW

Insured's Name_____Relationship to Patient_____SS#_____

Insurance Company_____Group #_____Subscriber ID#_____

Insurance Company Address_____Phone_____

EMERGENCY CONTACT

Name_____Relationship to Patient_____Phone_____

Address_____City_____State_____Zip_____

PHYSICIAN AND GENERAL DENTIST

Physician_____Date of Last Visit_____

Address_____Phone_____

General Dentist_____Date of Last Visit_____

Address_____Phone_____

MEDICAL HISTORY

Please circle YES or NO (If YES, please fill in details)

YES NO Is the patient taking any medication?_____
YES NO Is the patient allergic to any medications?_____
YES NO History of a major illness?_____
YES NO Has the patient had any surgeries?_____
YES NO Ever been involved in a serious accident?_____
YES NO Has seen a physician in the last 12 months? Why?_____

Female Patients Only

YES NO Has menstruation started?_____
YES NO Is the patient pregnant?_____

Circle any of the following medical conditions below that the patient has had or currently has.

Abnormal Bleeding/Hemophilia	Diabetes	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Problems	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

DENTAL HISTORY

What concerns you most about your teeth?_____

Please circle YES or NO (If YES, please fill in details)

YES NO Is the patient presently in any dental pain?_____
YES NO Ever experienced any unfavorable reaction to dentistry?_____
YES NO Has the patient ever lost or chipped any teeth?_____
YES NO Have there been any injuries to the face, mouth, or teeth?_____
YES NO Is any part of the mouth sensitive to temperature? Where?_____
YES NO Is any part of the mouth sensitive to pressure? Where?_____
YES NO Do gums bleed while brushing?_____
YES NO Any type of thumb or tongue habit?_____
YES NO Is the patient a mouth breather?_____
YES NO Has the patient ever seen an orthodontist? If yes, who and when?_____
YES NO Does the patient have a negative attitude or concerns about receiving treatment?_____
YES NO Has anyone in the family received orthodontic treatment?_____
How do they feel about the result?_____
YES NO Do teeth or jaw ever feel uncomfortable in the morning?_____
YES NO Experience jaw clicking or popping?_____
YES NO Aware of clenching or grinding teeth during the day?_____
YES NO Experience “tension” headaches?_____
YES NO Has the patient ever experienced chronic ringing in the ears?_____
YES NO Does the patient need extra help with instructions?_____
YES NO Is the patient sensitive/self-conscious about his/her teeth?_____
YES NO Are you aware that some appointments will be during school/work hours?_____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Camanocha to perform a complete orthodontic evaluation.

Signature_____Date_____