



Name: _____
Nickname: _____
Date of Birth: _____
School: _____

Child Patient Information:

Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>		Child's Dentist: _____
Address: _____		E-Mail: _____
City: _____		On Facebook: Yes <input type="checkbox"/> No <input type="checkbox"/>
Home Phone: _____	Cell Phone: _____	Work Phone: _____
Referred by: _____	How you know referred: _____	

Family Information:

The following information is requested so that we can communicate properly with the people involved with your child's treatment.

With whom does the patient live? _____

Who should receive routine information about treatment progress? _____

Parents Marital Status: Married Separated Divorced Other

Patient's Father

Last Name: _____ First Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip code: _____

E-Mail: _____ Occupation: _____ Employer: _____

Patient's Mother

Last Name: _____ First Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip code: _____

E-Mail: _____ Occupation: _____ Employer: _____

Brothers & Sisters

Name: _____ Age: _____ Patient: Yes No

Name: _____ Age: _____ Patient: Yes No

Name: _____ Age: _____ Patient: Yes No

Name: _____ Age: _____ Patient: Yes No

Dental History Status:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	When were you last seen by the dentist? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you taking any pills or medicine for dental reasons? Please list: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have there been any unusual reactions to dental medications?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had trouble associated with dental treatment?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you seen a periodontist, endodontist, or oral surgeon?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any previous orthodontic treatment or consultation? When? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any member of your family had orthodontic treatment?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any teeth extracted (pulled)? Why? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever injured or broken any teeth? When and what happened? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever injured the head or face? When and what happened? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any missing or extra teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any problem with eating, chewing or swallowing?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any dental or facial pain?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do your jaw joints make noise or hurt when opening, closing, or chewing?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you habitually grind or clench teeth together?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you normally breathe with the lips parted?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you aware of any swellings or growths in the mouth or your face?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any negative or resistant feelings about orthodontic treatment?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you especially concerned about orthodontic treatment?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you dissatisfied about the appearance of your teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you specifically resistant to: <input type="checkbox"/> Braces <input type="checkbox"/> Headgear <input type="checkbox"/> Retainers
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there any other information we should know? _____

My Favorite Kind of Music: _____

In My Spare Time I Like: _____

I Would Like Dr. Haney to Know: _____

My Favorite Book: _____

My Favorite TV Show: _____

My Favorite Food: _____

My Friends Who Also See Dr. Haney: _____

Sports I Like To Watch & Play: _____

Thanks for telling us about yourself
 We're excited to meet you soon!

Medical History:

Who is your physician? _____	Phone Number: _____	
When were you last seen by your physician? _____		
Have you ever seen an ENT specialist, endocrinologist, neurologist, psychologist, allergist, hematologist, cardiologist, psychiatrist, or plastic surgeon? (If YES , circle all that apply)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a current medical problem or condition?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking any pills, medications, or drugs?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had an unusual reaction to any medication?	
What is the patient allergic to? _____		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an injury to the head, face or mouth?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a serious illness? Have a history of a serious illness?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had any surgery or been hospitalized?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there any congenital (that you were born with) problems?	
Have you ever been diagnosed or treated for the following? (Circle all that apply):		
Diabetes Fainting Arthritis Anemia Heart trouble Kidney problem Liver problem Breathing trouble Prolonged bleeding	Bone disease Thyroid problem Epilepsy Hepatitis Jaundice AIDS or HIV + Asthma Tonsillitis Rheumatic fever	Cerebral palsy Multiple sclerosis Sickle cell anemia Tuberculosis Stomach ulcer Cancer Low blood pressure Emotional problems Nickel allergy

Reason for visit:

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. I understand that my diagnostic records may be used for educational and promotional purposes. 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. Haney to take orthodontic radiographs (x-rays) and perform a complete orthodontic evaluation.

Signature of responsible party	
Print Name	
Relationship to patient	
Date	