



D.D.S. M.S. BOARD CERTIFIED
SPECIALIST IN ORTHODONTICS

1551 S. WATER STREET
KENT, OHIO 44240
330.673.6411

PLEASE PRINT

DATE _____

NO. _____

PATIENT INFORMATION

LAST NAME		FIRST NAME		NICKNAME		S.S. NUMBER		SEX	BIRTHDATE	AGE
MAILING ADDRESS			CITY		STATE	ZIP	PHONE			
SCHOOL (if a student)		GRADE	<input type="radio"/> single <input type="radio"/> married <input type="radio"/> separated <input type="radio"/> divorced <input type="radio"/> widowed		EMPLOYED BY/OCCUPATION			BUSINESS PHONE		
REFERRED BY		NAME OF GENERAL DENTIST				DATE OF LAST VISIT				
RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE					NAMES AND AGES OF OTHER CHILDREN					
DOES THE PATIENT HAVE ORTHODONTIC INSURANCE? <input type="radio"/> YES <input type="radio"/> NO				PATIENT'S INTERESTS AND ACTIVITIES						

PARENT INFORMATION (if patient is a minor)

FATHER'S NAME		<input type="radio"/> single <input type="radio"/> married <input type="radio"/> separated <input type="radio"/> divorced <input type="radio"/> widowed	MAILING ADDRESS		CITY		STATE	ZIP
SOCIAL SECURITY NUMBER			PHONE		OCCUPATION/EMPLOYED BY			BUSINESS PHONE
MOTHER'S NAME		<input type="radio"/> single <input type="radio"/> married <input type="radio"/> separated <input type="radio"/> divorced <input type="radio"/> widowed	MAILING ADDRESS		CITY		STATE	ZIP
SOCIAL SECURITY NUMBER			PHONE		OCCUPATION/EMPLOYED BY			BUSINESS PHONE

MEDICAL HISTORY

DENTAL HISTORY

<p>Please check (✓) if patient has or has had:</p> <ul style="list-style-type: none"> <input type="radio"/> Joint swelling <input type="radio"/> Bone disorders <input type="radio"/> Heart trouble <input type="radio"/> Heart Murmur <input type="radio"/> Mitral valve prolapse <input type="radio"/> Rheumatic fever <input type="radio"/> Thyroid problems <input type="radio"/> Diabetes <input type="radio"/> Hepatitis <input type="radio"/> Nervous disorders <input type="radio"/> Brain injury <input type="radio"/> Tuberculosis <input type="radio"/> Anemia <input type="radio"/> Asthma <input type="radio"/> Epilepsy <input type="radio"/> Arthritis <input type="radio"/> Prolonged bleeding <input type="radio"/> Faintness/Dizziness <input type="radio"/> Tonsils removed <input type="radio"/> Adenoids removed <input type="radio"/> Sore throats <input type="radio"/> Tonsillitis <input type="radio"/> Earaches 	<p>Please check (✓) if answer is yes:</p> <ul style="list-style-type: none"> <input type="radio"/> Any injuries to face, mouth, teeth? (circle) <input type="radio"/> Thumb, finger, lip sucking? (circle) <input type="radio"/> Any missing permanent teeth? <input type="radio"/> Any speech problems? <input type="radio"/> Any difficulty in swallowing or chewing? <input type="radio"/> Any pain or clicking on opening mouth? <input type="radio"/> Does patient visit dentist regularly? <input type="radio"/> Has an orthodontist been consulted previously? Reason:
Has patient ever been hospitalized? <input type="radio"/> YES <input type="radio"/> NO If YES, for what reason?	What is your reason for seeking orthodontic treatment?
List any serious illnesses:	Patient's attitude toward orthodontic treatment: (circle one) Very motivated Will cooperate if needed Not motivated
List any allergies:	Is patient adopted? <input type="radio"/> YES <input type="radio"/> NO At what age?
List drugs or medications now being taken:	Any other information that would be helpful to us:
Is patient under physician's care presently? <input type="radio"/> YES <input type="radio"/> NO If YES, for what reason?	
Name of Physician:	
Females: Has menstruation begun? <input type="radio"/> YES <input type="radio"/> NO Date (month/year):	Your e-mail address:

Signature of Patient or of Parent or Guardian if Patient is a Minor

Updated: _____