Sullivan ORTHODONTICS

Child Patient Information

Patient Information

Date	
Patient's Name	
Preferred Name/Nickname	
Address	
Birth Date	**Age**
Sex ❑ Male ❑ Female	
Primary Phone	
Cell Phone	
Work Phone	
Have we treated any other family members? ❑ Yes ❑ No	
Names of family members treated	
If patient is a minor, give parent's or guardian's name	

Responsible Party Information

Name	
Address	
How long at this address	
Previous Address (if less than 3 yrs)	
E-Mail Address	
Primary Phone	**Cell Phone**
Work Phone	**Birth Date**
Relationship to Patient	
Employer	
Occupation	
No. Years Employed	
Marital status: ❑ single ❑ married ❑ partner ❑ divorced ❑ widowed	
Spouse/Partner	
Cell Phone	**Work Phone**
Birth Date	
Relationship to Patient	
Employer	
Occupation	
No. Years Employed	

Orthodontic Insurance Information

Insured's Name	
Birth Date	**SSN**
Insurance Company	

Orthodontic Insurance Information

Group No.	
Local No.	
Insurance Co Address	
Phone	
Do you have dual coverage? ❑ Yes ❑ No	
2nd Insured's Name	
Birth Date	**SSN**
Insurance Company	
Group No.	
Local No.	
Insurance Co Address	
Phone	

Emergency Information

Emergency Contact Person (not living with you)
Complete Address
Phone

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Child Medical Information

Medical History

Patient's Name			
For the questions check yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.			
Patient Profile			
	yes	**no**	**dk/u**
Does patient follow directions well?	❑	❑	❑
Does patient brush his/her teeth conscientiously?	❑	❑	❑
Does patient have learning disabilities or need extra help with instructions?	❑	❑	❑
Is patient sensitive or self-conscious about teeth?	❑	❑	❑

Now or in the past has the patient had any of the following: (If yes please explain)

	yes	**no**	**dk/u**	
Birth defects or hereditary problems?	❑	❑	❑	
Bone fractures, any major accidents?	❑	❑	❑	
Rheumatoid or arthritic conditions?	❑	❑	❑	
Endocrine or thyroid problems?	❑	❑	❑	
Kidney problems?	❑	❑	❑	
Diabetes?	❑	❑	❑	
Cancer, tumor, radiation treatment or chemotherapy?	❑	❑	❑	
Stomach ulcer or hyperacidity?	❑	❑	❑	
Polio, mononucleosis, tuberculosis or pneumonia?	❑	❑	❑	
Problems of the immune system?	❑	❑	❑	
AIDS or HIV positive?	❑	❑	❑	
Hepatitis, jaundice or liver problem?	❑	❑	❑	
Fainting spells, seizures, epilepsy or neurological problem?	❑	❑	❑	
Mental health disturbance or behavioral problem?	❑	❑	❑	
Vision, hearing, tasting or speech difficulties?	❑	❑	❑	
Loss of weight recently, poor appetite?	❑	❑	❑	

Medical History

	yes	no	dk/u	
History of eating disorder (anorexia/bulimia)?	❑	❑	❑	
Excessive bleeding or bruising tendency, anemia or bleeding disorder?	❑	❑	❑	
High or low blood pressure?	❑	❑	❑	
Tires easily?	❑	❑	❑	
Chest pain, shortness of breath or swelling ankles?	❑	❑	❑	
Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease?	❑	❑	❑	
Skin disorder?	❑	❑	❑	
Frequent headaches, colds or sore throats?	❑	❑	❑	
Eye, ear, nose or throat condition?	❑	❑	❑	
Hayfever, asthma, sinus trouble or hives?	❑	❑	❑	
Tonsil or adenoid conditions?	❑	❑	❑	
Allergies or reactions to any of the following:				
	yes	**no**	**dk/u**	
Local anesthetics (Novocaine or Lidocaine)	❑	❑	❑	
Aspirin	❑	❑	❑	
Ibuprofen (Motrin, Advil)	❑	❑	❑	
Penicillin or other antibiotics	❑	❑	❑	
Sulfa drugs	❑	❑	❑	
Codeine or other narcotics	❑	❑	❑	
Metal (jewelry, clothing snaps)	❑	❑	❑	
Latex (gloves, balloons)	❑	❑	❑	
Vinyl	❑	❑	❑	
Acrylic	❑	❑	❑	
Animals	❑	❑	❑	
Foods (specify)	❑	❑	❑	
Other substances (specify)	❑	❑	❑	
Medications				

Medical History

	yes	no	dk/u	
Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine?	❑	❑	❑	

Please list all medications

Medication	**Taken for**
Medication	**Taken for**
Medication	**Taken for**

	yes	no	dk/u	
Does the patient currently have or ever had a substance abuse problem?	❑	❑	❑	
Does the patient chew or smoke tobacco?	❑	❑	❑	
Operations? Describe:	❑	❑	❑	
Hospitalized? For:	❑	❑	❑	
Other physical problems or symptoms? Describe:	❑	❑	❑	
Being treated by another health care professional? For:	❑	❑	❑	
Date of most recent physical exam?	❑	❑	❑	

Are there any other medicial conditions that we should be aware of:

Family Medical History

Girls Only

	yes	no	dk/u	
Has the patient started her monthly periods? If so, approximately when?	❑	❑	❑	

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

	yes	no	dk/u	
Bleeding disorders	❑	❑	❑	
Diabetes	❑	❑	❑	
Arthritis	❑	❑	❑	
Metabolic disturbances	❑	❑	❑	
Severe allergies	❑	❑	❑	
Unusual dental problems	❑	❑	❑	
Jaw size imbalance	❑	❑	❑	
Any other family medical conditions that we should know about?	❑	❑	❑	

Name of Physician	**Phone Number**
Location	**Last Visit**

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Dental Information

Dental History

Patient's Name			
Dentist's Name		**Specialist or Other**	
What is your primary concern?			
For the questions check yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.			
Now or in the past, has the patient had:			
	yes	**no**	**dk/u**
Permanent or "extra" (supernumerary) teeth removed?	❑	❑	❑
Supernumerary (extra) or congenitally missing teeth?	❑	❑	❑
Chipped or otherwise injured primary (baby) or permanent teeth?	❑	❑	❑
Teeth sensitive to hot or cold, teeth throb or ache?	❑	❑	❑
Jaw fractures, cysts or mouth infections?	❑	❑	❑
"Dead teeth" or root canals treated?	❑	❑	❑
Bleeding gums, bad taste or mouth odor?	❑	❑	❑
Periodontal "gum problems"?	❑	❑	❑
Food impaction between teeth?	❑	❑	❑
"Gum boils", frequent canker sores or cold sores?	❑	❑	❑
Abnormal swallowing habit (tongue thrusting)?	❑	❑	❑
History of speech problems?	❑	❑	❑
Mouth breathing habit, snoring or difficulty in breathing?	❑	❑	❑
Tooth grinding, jaw clenching clicking or locking?	❑	❑	❑
Any pain in jaw or ringing in the ears?	❑	❑	❑
Any pain or soreness in the muscles of the face or around the ears?	❑	❑	❑
Difficulty in chewing or jaw opening?	❑	❑	❑
Have you even been treated for "TMD" or "TMJ" problems?	❑	❑	❑
Thumb, finger, or sucking habit? Until what age?	❑	❑	❑
.			

Dental History

	yes	no	dk/u
Aware of loose, broken or missing restorations (fillings)?	❑	❑	❑
Any teeth irriating cheek, lip, tongue or palate?	❑	❑	❑
Concerned about spaced, crooked or protruding teeth?	❑	❑	❑
Aware or concerned about under or over developed jaw?	❑	❑	❑
Any relative with similar tooth or jaw relationships?	❑	❑	❑
Any wisdom tooth problems?	❑	❑	❑
Had periodontal (gum) treatment?	❑	❑	❑
Had any serious trouble associated with any previous dental treatment?	❑	❑	❑
Would you object to wearing orthodontic appliances (braces) should they be indicated?	❑	❑	❑
Ever had a prior orthodontic examination or treatment?	❑	❑	❑
Current dentist's care?	❑	❑	❑
How often do you brush?		**Floss?**	

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Patient Signature:

Date: