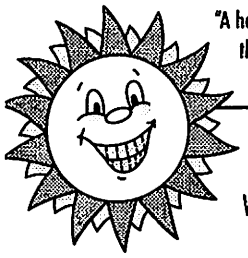

"A healthy smile... the start of a bright future!"

Michele A. Bernardich, DMD, MSD

Orthodontics for Children and Adults

WELCOME TO THE ORTHODONTIST

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOUR CHILD

Today's Date:_____

Child's Name: _____

Nickname:_____ ☐ Male ☐ Female

Child's Birthdate:_____ Child's Age:_____

School:_____ Grade:_____

Hobbies/Sports:_____

Child's Home Phone#:_____

Child's Home Address:_____

_____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name:_____ Relation:_____

Do you have legal custody of this child? ☐ yes ☐ no

Whom may we thank for referring you?_____

List Brothers/Sisters with ages:_____

Family Physician:_____

General Dentist:_____ Last Visit:_____

How often does pt. brush: _____ Floss:_____

Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced

☐ Widowed ☐ Separated

Mother's Information or ☐ Stepmother ☐ Guardian

Name:_____ Birthdate:_____

Work #_____ Ext._____ Home #_____

Social Security Number_____ Occup._____

Employer_____

Father's Information or ☐ Stepfather ☐ Guardian

Name:_____ Birthdate:_____

Work #_____ Ext._____ Home #_____

Social Security Number:_____ Occup._____

Employer_____

Primary Orthodontic Insurance

Orthodontic Coverage ☐ Yes ☐ No

Lifetime Benefit_____ Amount Used:_____

Insurance Company Name:_____

Insurance Company Address:_____

_____

Phone #_____ Group#_____

Name of Insured_____

Relationship to Patient:_____

Insured's Birthdate_____ S.S.# _____

Insured's Employer_____

Secondary Orthodontic Insurance

Lifetime Benefit_____ Amount Used:_____

Insurance Company Name:_____

Insurance Company Address:_____

_____

Phone #_____ Group #_____

Name of Insured_____

Relationship to Patient:_____

Insured's Birthdate_____ S.S.# _____

Insured's Employer_____

Person Responsible For Account

Name:_____ Relation:_____

Billing Address:(if different from child):

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N AIDS/ARC/HIV+
Y N Allergies List _____
Y N Anemia
Y N Artificial Joints/Bone Pins
Y N Asthma/Hayfever
Y N Birth Defects
Y N Bone Fractures
Y N Diabetes
Y N Endocrine or Thyroid Problems
Y N Epilepsy, Seizures, Fainting spells
Y N Excessive bleeding/Blood diseases
Y N Handicaps/Disabilities
Y N Headaches (severe, frequent)
Y N Head Injuries
Y N Heart Disease
Y N Heart Murmur
Y N Hearing Problems/Disorders
Y N Hepatitis
Y N Jaundice, Liver Disease
Y N Low/High Blood Pressure
Y N Kidney Disease
Y N Mental Problems
Y N Mitral Valve Prolapse
Y N Nerve Disorders
Y N Radiation Treatment
Y N Respiratory Treatment
Y N Rheumatic Fever/Scarlet Fever
Y N Rheumatism, Arthritis
Y N Sinus Troubles
Y N Stroke
Y N Stomach Ulcer
Y N Tuberculosis, Polio, Mono or Pneumonia
Y N Venereal Diseases
Y N Cancer/Chemotherapy
Y N Behavior Problems Explain: _____
Y N Is patient in good physical health?
Y N History of any major illnesses or operations? List _____

_____

List current medications _____

Has puberty begun? Y N Boys.....voice change? Y N
Girls....menstruation begun? Y N

Patient's Height _____ Patient's Weight _____
Mother's Height _____ Father's Height _____
Has an Orthodontist been consulted previously? _____
Has patient had prior orthodontic treatment? Explain _____

_____

Has either parent had orthodontic treatment? _____
What is the primary concern for today's visit? _____

DENTAL HISTORY?

Y N Started teething very early or late?
Y N Primary (baby) teeth removed that were not loose?
Y N Permanent or "extra" teeth removed?
Y N Supernumerary "extra" or congenitally missing teeth?
Y N Chipped or otherwise injured teeth?
Y N Teeth sensitive to hot or cold, teeth throb or ache?
Y N Jaw fractures, or mouth infections?
Y N "Dead teeth" root canals treated?
Y N Bleeding gums, mouth odor?
Y N Periodontal "Gum" problems?
Y N Canker sores or fever blisters?
Y N Is child taking a fluoride supplement?
Y N Thumb, finger, sucking habit? Until _____
Y N Abnormal swallowing habit (tongue thrust)?
Y N History of speech problems?
Y N Mouth breathing habit, snoring, difficulty breathing?
Y N Tooth grinding, jaw clenching, clicking or locking?
Y N Any pain in jaw or ringing in the ears?
Y N Does the patient experience any pain or soreness in the muscles of the face, or around the ears?
Y N Difficulty encountered in chewing or jaw opening?
Y N Aware of loose, broken or missing restorations (fillings)?
Y N Any teeth irritating cheek, lip, tongue, or palate?
Y N Concerned about spaced, crooked, protruding teeth?
Y N Aware or concerned about under or over developed jaw?
Y N Any relative with similar tooth or jaw relationships?
Y N Any wisdom tooth problems? Have they been removed? Date _____
Y N Does patient play a musical instrument? List _____

Does patient have a learning disability? _____
Does patient need special help with instructions? _____
_____

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.

_____
Signature of parent or guardian Date

I verbally reviewed the medical/dental information above with the parent/guardian named herein.

Initials: _____ Date: _____

Doctor's Comments: _____
_____
_____
_____
_____

Date _____

Health Changes _____
_____
_____
_____

CURRENT MEDICATIONS

1. _____
2. _____
3. _____
4. _____

Patient's Signature _____ Staff Initials _____