

MEDICAL HISTORY

Physician / Pediatrician _____ Date of Last Visit _____
Is the patient in good health? Yes No
Is the patient under the care of physician for a specific problem at this time? Yes No Illness: _____
Please list any medicines the patient is currently taking: _____
Please list any drug allergies or sensitivities: _____
Does the patient have a history of a serious illness, accident, or operation? Yes No Please Describe: _____
Has the patient reached puberty? Girl: Has she started menstruation? Yes No If yes, month / year: _____
Is the patient pregnant? Yes No
Boy: Has his voice changed? Yes No

Please CIRCLE any of the following medical conditions that apply

- Diabetes Epilepsy Dizziness Rheumatic Fever Abnormal Bleeding / Hemophilia
- Pneumonia Arthritis HIV / AIDS Ear Infections / Tubes Prolonged Bleeding
- Bone Disorders Herpes Asthma High Blood Pressure Radiation/Chemotherapy
- Heart Murmur Anemia Cancer Rheumatic Fever Congenital Heart Defect
- Heart Problems Tuberculosis Kidney problems Emotional / Nervous Disorders

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? _____
Yes No Is the patient presently in any dental pain? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Has the patient ever sucked a thumb or fingers? Until what age? _____
Yes No Is the patient a mouth breather?
Yes No Do the patient's gums bleed when brushing?

Please CIRCLE any of the following that apply

- Clenching / Grinding Teeth Jaw Joint Soreness Frequent *Tension* Headaches
- Jaw Joint Clicking or Popping Frequent Ringing in the Ears Head and Neck Muscle Soreness

Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
What is the patient's attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Is the patient concerned or sensitive about the appearance of his/her teeth or smile? _____
What part of your child's orthodontic problem concerns you most? _____
Yes No Are you open to the idea of baby teeth and/or adult teeth being removed if necessary for treatment?
Yes No Does the patient need extra help with instructions?
Additional information you feel would make your child's association with us more enjoyable: _____
Yes No Are you aware that some appointments will be during school hours?

BENEFITS

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 or change in the position of the teeth after treatment. I have read and understand this paragraph. I also understand that my child's diagnostic records and name 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 child's medical or dental history. In addition, I authorize Mitchell & Bartlett Orthodontics to perform a complete orthodontic evaluation.

Signature of Parent or Guardian: _____ Date: _____