Welcome to Mitchell & Bartlett Orthodontics

Our goal is to help your child reach and maintain good oral health and a beautiful smile that will last a lifetime

Tell us about your child:

Todays Date: _____

Child's name: First _____ Last: _____ Preferred name: _____ M / F

Birthdate: _____ Age: _____ School: _____

Hobbies / Sports: _____

Was Child adopted: Yes / No

Child's Home Address: _____

City: _____ State: _____ Zip code: _____

Child's home phone #: _____

Other family members seen by us: _____

General Dentist: _____ Date of last cleaning / visit: _____

Whom may we thank for referring you? _____

Who is accompanying your child today: _____ Relation: _____

Do you have legal custody of this child: Yes / No

Parental Information

Circle: Parent Step-Parent Guardian M / F

Name: _____ DOB: _____

Address: _____

City: _____ St: _____ Zip: _____

Employer: _____

Occupation: _____

Work #: _____ Cell #: _____

Email: _____

Circle: Parent Step-Parent Guardian M / F

Name: _____ DOB: _____

Address: _____

City: _____ St: _____ Zip: _____

Employer: _____

Occupation: _____

Work #: _____ Cell #: _____

Email: _____

Parental marital status (circle one): Single Married Separated Divorced Partnered

Who is financially responsible for account: _____

Primary Dental Insurance

Orthodontic coverage: Yes / No

Insurance Co. name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____

Policy Owner's Name: _____

Policy Owner's Birthdate: _____

Relationship to Patient: _____

Subscriber ID#: _____

Policy Owner's Employer: _____

SS#: _____

Secondary Dental Insurance

Orthodontic coverage: Yes / No

Insurance Co. name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____

Policy Owner's Name: _____

Policy Owner's Birthdate: _____

Relationship to Patient: _____

Subscriber ID#: _____

Policy Owner's Employer: _____

SS#: _____

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, 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 experience 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: _____