DUBUQUE ORTHODONTIC ASSOCIATES, P.C.
PATIENTS UNDER 18 YEARS OF AGE

Welcome to our office!

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for the orthodontist to thoroughly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information is important for our records and your health. I understand that providing incorrect information can be dangerous to my child's health. Please circle the appropriate response where indicated.

Thank you.

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____ Age: _____ Sex: Male or Female I prefer To Be Called: _____

Home Phone No.: _____ Patient Cell Phone No.: _____

Patient's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Attends School At: _____ Musical Instruments Played: _____

Sports And/Or Hobbies: _____

No. Of Brothers: _____ Ages: _____ No. Of Sisters: _____ Ages: _____

First & last names of other family members treated here: _____

_____

Father's Name: _____ Mother's Name: _____

Father's Cell Phone No.: _____ Mother's Cell Phone No.: _____

Custodial Parent(s) or Guardian(s): _____

Patient Living With: Mother Father Other: _____

Phone No. *(if different than patient's)*: _____

Address *(if different than patient's)*: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Name of Patient's Dentist: _____ Date of last checkup: _____

Were the patient's teeth cleaned? Yes No

Who is Financially Responsible For This Account?

Last Name: _____ First Name: _____ M/Mrs. Ms. Dr. Rev. Other

Address *(if different from patient's)*: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Father's Employer: _____ Insurance Coverage for Orthodontic Treatment? Yes No

Mother's Employer: _____ Insurance Coverage for Orthodontic Treatment? Yes No

***It is your responsibility to inform us if your insurance needs to be pre-authorized before the appliances are placed.**

Primary Policy Holder's Name: _____ S.S.N./S.I.N. _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____

Secondary Policy Holder's Name: _____ S.S.N./S.I.N. _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____

For the following questions circle 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?
yes no dk/u Does patient brush his/her teeth conscientiously?
yes no dk/u Is the patient aware of any orthodontic problem?
yes no dk/u Does patient have learning disabilities or need help with instructions?
yes no dk/u Is patient sensitive or self-conscious about teeth?

How often does your child brush: _____ Floss: _____

Patient's interest in orthodontic treatment: (circle one)

The Patient Wants Treatment | Treatment if Necessary | Unwilling But Agrees | Uncooperative

Orthodontic consultation prompted by: Self Dentist Mother Father Sibling Physician
Friend Other (Specify):_____

What is your primary concern? Why are you here? _____

What is expected from orthodontic treatment? _____

MEDICAL HISTORY

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

yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/u Tired easily?
yes no dk/u Chest pain, shortness of breath or swelling ankles?
yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
yes no dk/u Skin Disorder?
yes no dk/u Does the patient eat a well-balanced diet?
yes no dk/u Frequent headaches, colds or sore throats?
yes no dk/u Eye, ear, nose or throat condition?
yes no dk/u Hay fever, asthma, sinus trouble or hives?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Tonsils Removed? Date:_____
yes no dk/u Adenoids Removed? Date:_____

Allergies or reactions to any of the following:

yes no dk/u Local anesthetics (Novocaine or Lidocaine)
yes no dk/u Aspirin
yes no dk/u Ibuprofen (Motrin, Advil)
yes no dk/u Penicillin or other antibiotics
yes no dk/u Sulfa Drugs
yes no dk/u Codeine or other narcotics
yes no dk/u Metals (jewelry, clothing snaps)

yes no dk/u Latex (gloves, balloons)
yes no dk/u Vinyl
yes no dk/u Acrylic
yes no dk/u Animals
yes no dk/u Foods (specify) _____
yes no dk/u Other substances (specify) _____

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

Medication _____ Taken for _____
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?
yes no dk/u Does the patient chew or smoke tobacco?
yes no dk/u Operations? Describe:_____
yes no dk/u Hospitalized? Describe: _____
yes no dk/u Other physical problems or symptoms? Describe: _____
_____
yes no dk/u Being treated by another health care professional? Date of most recent physical exam: _____
For: _____
yes no dk/u Do you have any other medical conditions that we should know about? _____
_____

FEMALES ONLY

yes no dk/u Has the patient started her monthly periods?
If so, approximately when? _____
yes no dk/u Is the patient pregnant? If yes, please provide due date:_____

Now or in the past, has the patient had:

yes no dk/u Started teething very early or late?
yes no dk/u Primary (baby) teeth removed that were not loose?
yes no dk/u Permanent or "extra" (supernumerary) teeth removed?
yes no dk/u Supernumerary (extra) or congenitally missing teeth?
yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u Jaw fractures, cysts or mouth infections?
yes no dk/u "Dead teeth" or root canals treated?
yes no dk/u Bleeding gums, bad taste or mouth odor?
yes no dk/u Periodontal "gum problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u Thumb, finger, or sucking habit?
yes no dk/u Until what age _____?
yes no dk/u Abnormal swallowing habit (tongue thrusting)?
yes no dk/u History of speech problems?
yes no dk/u Mouth breathing habit, snoring or difficulty in breathing?
yes no dk/u Tooth grinding or jaw clenching?
yes no dk/u Any pain in jaw or ringing in the ears?
yes no dk/u Any pain or soreness in the muscles of the face or around the ears?
yes no dk/u Difficulty encountered in chewing or jaw opening?
yes no dk/u Aware of loose, broken or missing restorations (fillings)?
yes no dk/u Any teeth irritating cheek, lip, tongue or palate?
yes no dk/u Concerned about spaced, crooked or protruding teeth?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u "Gum boils", frequent canker sores or cold sores?
yes no dk/u Taking any forms of fluoride?
yes no dk/u Any relative with similar tooth or jaw relationships?
yes no dk/u Had peridontal (gum) treatment?
yes no dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?
yes no dk/u Any serious trouble associated with any previous dental treatment?
yes no dk/u Ever had a prior orthodontic examination or treatment?
yes no dk/u Been under another dentist's care?
Specialist _____
Other _____

I have read and understand the above questions. I will not hold Dubuque Orthodontic Associates, P.C. 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.

NOTE: EXAM APPOINTMENTS ARE NO CHARGE.
IF DIAGNOSTIC RECORDS (INCLUDING X-RAYS) ARE TAKEN AND TREATMENT IS NOT PURSUED, THERE WILL BE A CHARGE OF $280.00

Signed: _____ Date Signed: _____
(Parent or Guardian)