

New Patient Form for Patients Under 18 Years of Age
Dubuque Orthodontic Associates

Patient's First Name: _____ M.I. ____ Last Name: _____

Birthdate: ____/____/____ Age: ____ Sex: Male Female I prefer to be called: _____

Cell Phone: (____) ____ - _____

Email: _____

Patient Address: _____

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

Attends School At: _____

Sports/Hobbies: _____

No. of Siblings: ____ Ages: _____

Name of other family members treated here:

Father's Name: _____ Father's Phone: (____) ____ - _____

Mother's Name: _____ Mother's Phone: (____) ____ - _____

Custodial Parent/Guardian: _____ Relationship to patient: _____

Phone (if different than patient): (____) ____ - _____

Address (if different than patient): _____ City: _____

State: _____ Zip/Postal Code: _____

Patient living with: Mother Father Other: _____

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

Who is financially responsible for this account?

First Name: _____ Last Name: _____

Address (if different than patient): _____ City: _____

State: _____ Zip/Postal Code: _____

Email address: _____

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 or has a waiting period before the start of treatment*****

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

Birthdate: ____/____/____ Employed by: _____

Dental Insurance Company: _____

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

Birthdate: ____/____/____ Employed by: _____

Dental Insurance Company: _____

Patient Profile (please circle yes, no, or dk for "don't know")

Yes No dk Does patient have learning disabilities or need help with instructions?

Yes No dk Is patient sensitive or self-conscious about teeth?

What is your primary concern? What brings you to us? _____

Medical History (please circle yes, no, or dk for "don't know")

- Yes No dk Birth defects or hereditary problems? _____
- Yes No dk Heart/cardiovascular problem? _____
- Yes No dk Repaired/unrepaired heart defects? _____
- Yes No dk Cancer, radiation, or chemotherapy? _____
- Yes No dk Arthritic conditions? _____
- Yes No dk Osteoporosis or other bone disorder? _____
- Yes No dk Stomach ulcers, GERD, or hyperacidity? _____
- Yes No dk Immune system problems? _____
- Yes No dk Diabetes? _____
- Yes No dk History of epilepsy, seizures, fainting? _____
- Yes No dk Eye, ear, nose, or throat condition? _____
- Yes No dk AIDS/HIV positive? _____
- Yes No dk Polio, mononeucleosis, tuberculosis, pneumonia? _____
- Yes No dk Tobacco/Alcohol use? _____
- Yes No dk Operations/hospitalized? _____
- Yes No dk Any other past/current conditions? _____

Allergies or reactions to any of the following:

- Yes No dk Local anesthetics (Novocaine or Lidocaine) Yes No dk Latex (gloves, balloons, etc.)
- Yes No dk Ibuprofen (Motrin, Advil) Yes No dk Penicillin or other antibiotics
- Yes No dk Metals (jewelry, clothing snaps) Yes No dk Acrylics
- Yes No dk Other (specify) _____

Please list medications, supplements, or nonprescriptive medicine and what they are taken for:

- Medication: _____ Taken for: _____
- Medication: _____ Taken for: _____
- Medication: _____ Taken for: _____
- Medication: _____ Taken for: _____

Females Only

- Yes No dk Is the patient pregnant? If yes, please provide due date: ____/____/_____
- Yes No dk Started monthly periods? If so, approximately when: _____

Dental History

- Yes No dk Injuries to face, teeth, lips? _____
- Yes No dk Extra or missing teeth? _____
- Yes No dk Jaw pain or soreness in facial muscles? _____
- Yes No dk History of thumb or finger sucking habit? Until what age? _____

Airway History

- Yes No dk Clenching or grinding teeth? _____
- Yes No dk Mouth breathing habit, snoring, or difficulty breathing? _____
- Yes No dk Tonsils and/or adenoids Removed? Approximate Date: ____/____/_____

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 FREE OF CHARGE. DIAGNOSTIC RECORDS (INCLUDING X-RAYS, SCANS, PHOTOS) WILL INCLUDE A CHARGE OF \$200.00 AT THE RECORDS VISIT COUNTED AS A DEPOSIT TOWARDS TREATMENT.

Signed: _____ Date Signed: ____/____/_____

(Parent or Guardian)