

Date: \_\_\_/\_\_\_/\_\_\_

### Patient Information

Child's Name: \_\_\_\_\_  
Last First Middle

SS#: \_\_\_/\_\_\_/\_\_\_      Nickname: \_\_\_\_\_      Male \_\_\_ Female \_\_\_

Address: \_\_\_\_\_  
Street Town/City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Birth date: \_\_\_/\_\_\_/\_\_\_      Age: \_\_\_\_\_

School: \_\_\_\_\_      Grade: \_\_\_\_\_      Hobbies/sports: \_\_\_\_\_

Patient Email: \_\_\_\_\_@\_\_\_\_\_

Who is accompanying the patient today: \_\_\_\_\_      Relation: \_\_\_\_\_

Do you have legal custody of this child? \_\_\_Yes \_\_\_No      Other siblings/ages: \_\_\_\_\_

**Whom may we thank for referring you to our office?** \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

### Parent's Information

Parent's Marital Status: \_\_\_Single \_\_\_Married \_\_\_Widowed \_\_\_Divorced \_\_\_Separated \_\_\_Re-married

Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_      Birth date: \_\_\_/\_\_\_/\_\_\_      Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Driver's License #: \_\_\_\_\_      E-mail address: \_\_\_\_\_@\_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street Town/City State Zip

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_      Title: \_\_\_\_\_      Years with Employer: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_      Birth date: \_\_\_/\_\_\_/\_\_\_      Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Driver's License #: \_\_\_\_\_      E-mail address: \_\_\_\_\_@\_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street Town/City State Zip

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_      Title: \_\_\_\_\_      Years with Employer: \_\_\_\_\_

Is either parent in the military? \_\_\_Yes \_\_\_No      Name: \_\_\_\_\_

If so, which of the armed forces? (Please **CIRCLE**)      US Army      US Navy      Marine Corps      Coast Guard

**Who is the responsible party for the account?** \_\_\_\_\_

### Dental Insurance Information

Dental Coverage: \_\_\_Yes \_\_\_No      Orthodontic Coverage: \_\_\_Yes \_\_\_No

Insured's Name: \_\_\_\_\_      Insured's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Company: \_\_\_\_\_      Group #: \_\_\_\_\_      ID #: \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_      Phone #: \_\_\_\_\_

## Emergency Information

Name of nearest relative not living with you: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Street

Town/City

State

Zip

## MEDICAL HISTORY

Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CIRCLE Yes or No** to the following questions (If Yes, please fill in details):

Yes No Are you taking any medication? \_\_\_\_\_

Yes No Are you allergic to any medication? \_\_\_\_\_

Yes No Do you have a history of a major illness? \_\_\_\_\_

Yes No Have you had any major operations? \_\_\_\_\_

Yes No Have there been any injuries to the face, mouth, teeth or chin? \_\_\_\_\_

**CIRCLE** any of the medical conditions below that the patient had or currently has:

Abnormal Bleeding/Hemophilia

Epilepsy

Nervous Disorders

ADD/ADHD

Gastrointestinal Disorders

Herpes

Rheumatic Fever

Anemia

Handicap/Disability

Radiation/Chemotherapy

Asthma or Hay Fever

Sickle Cell

Kidney Problems

Hearing Impairment

Heart Murmur

Cancer

Liver Problems

Tuberculosis

Congenital Heart Defect

Diabetes

Hepatitis/Liver problems

Mitral Valve Prolapse

Please list any medical conditions we have not discussed that you feel we should be aware of: \_\_\_\_\_

## DENTAL HISTORY

Patient's Dentist: \_\_\_\_\_

Date of last dental visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

**What concerns you most about the patient's teeth?** \_\_\_\_\_

**CIRCLE Yes or No** to following for the patient being seen today:

Yes No Is the patient presently in any dental pain? \_\_\_\_\_

Yes No Has the patient ever experienced any unfavorable reaction to dentistry?

Yes No Has the patient ever lost or chipped any teeth?

Yes No Do the patient's gums bleed when they brush?

Yes No Does the patient have any type of thumb or tongue habit?

Yes No Have you or the patient ever seen an orthodontist? If yes, who and when? \_\_\_\_\_

Yes No Has anyone in your family received orthodontic treatment?

How did they feel about the result? \_\_\_\_\_

Yes No Is the patient experiencing any jaw clicking or popping?

Yes No Have you ever been told that you grind your teeth?

Yes No Does the patient have "tension" headaches?

How does the patient feel toward receiving orthodontic treatment? Enthusiastic Motivated Neutral Disinterested

**Female Patients only:**

Yes No Is the patient pregnant?

Yes No Has menstruation started for this patient?

Benefits of Orthodontics

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth and face, the function of the teeth, supporting muscles and jaw joints (TMJ), and general dental health. Teeth, gums and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged/infected 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 of teeth and some change after treatment. I have read and understand this paragraph; I also understand that my diagnostic records and my 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 medical or dental history. In addition, I authorize Dr. Smith to perform a complete orthodontic evaluation.

Signature: \_\_\_\_\_

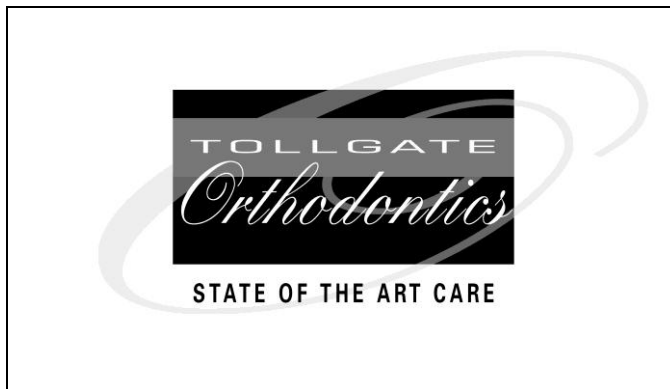
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Acknowledgment of Privacy Policy

I, \_\_\_\_\_ (please print first and last name), am aware that a copy of this office's Notice of Privacy Practices is available at request.

In subject of minor child, I have listed below person(s) who may be involved in his/her orthodontic updates and/or transportation.

- 1. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_
- 2. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_
- 3. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_
- 4. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_



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