

(Child)

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Southern Minnesota Orthodontics

Drs. Kanyusik, Wiemers & Swanson

Patient # _____

Date: _____

Please assist us by completing the following questions:

Patient's Name: _____ Sex: _____ Age: _____ Birthdate: _____

Nickname: _____ Referred by: _____

Address: _____ City: _____ Zip: _____ Home E-mail: _____

School: _____ Grade: _____ Home #: _____

Father's Name: _____ Occupation: _____ Cell #: _____

Father's Social Security #: _____ Father's Employer: _____ E-mail: _____

Mother's Name: _____ Occupation: _____ Work Phone: _____

Mother's Social Security #: _____ Mother's Employer: _____ E-mail: _____

Parent's Marital Status: Single Married Remarried Separated Divorced Widowed

#Sisters _____ #Brothers _____ Work Phone: _____

Family Rank _____

Patient lives with Mother Father Other: _____

Person Responsible for Account: Father Mother Other (Print Name): _____

Address: _____ Business Phone: _____ Home: _____

Cell: _____

ORTHODONTIC INSURANCE

Primary Insurance Co: _____ Gr. #: _____ Ortho Coverage: Yes No

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ SS#: _____ Birthdate: _____

Secondary Insurance Co: _____ Gr. #: _____ Ortho Coverage: Yes No

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ SS#: _____ Birthdate: _____

I authorize payment to be made directly to the orthodontist who has provided these services. Signature _____ Date _____

DENTAL HISTORY

1. Patient's Dentist: _____ Date of Last Visit: _____

2. Have there been any injuries to the face, mouth or teeth? YES NO

3. Has the patient had or does he/she presently have any of the following habits? Thumb or finger sucking Lip biting

NO Grinding of teeth at night Mouth breathing

4. Has the patient been informed of any missing or extra permanent teeth? YES NO

5. Is the patient aware of sores, lumps or irritated areas in the mouth? YES NO

6. Has an orthodontist been consulted previously? YES NO

Name: _____ Date: _____

7. Has the patient ever been treated for: Bite problem TMJ Periodontal disease

If so, by whom? NO

8. Does the patient have any speech problems? YES NO

9. Is the patient frightened or anxious about orthodontic treatment? YES NO

10. Is the patient concerned about the appearance of his/her teeth? YES NO

11. Is there anything the patient would like to change about his/her smile? YES NO

If so, what: _____

12. Reason for consultation: _____

13. Has there ever been any orthodontic treatment for any other member of your family? YES NO

Father (Dr. _____) Mother (Dr. _____) Brothers (Dr. _____) Sisters (Dr. _____)

14. Are you satisfied with their results? YES NO (over)

MEDICAL HISTORY

1. What is the name of the patient's family physician? _____ Date of last physical: _____
2. Has the patient reached puberty? YES NO
 Girls - started menstruating? Mo. ____ Yr. ____ YES NO
 Boys - voice changed? YES NO
3. Has the patient shown signs of increased growth recently? YES NO
4. Father's present height: _____ Mother's present height: _____
 Older brother's present height & age: _____ Older sister's present height & age: _____
5. What is the patient's approximate height? _____
6. Is the patient's general health good at this time? YES NO
7. Is the patient under the care of a physician at this time? YES NO
 Explain: _____
8. Is the patient taking any medication? YES NO
 Name: _____
9. Is the patient allergic to any medication? YES NO
 Name: _____
10. Has the patient had tonsils and adenoids removed? YES NO
 Age: _____
11. Has the patient ever had a serious illness or been hospitalized? YES NO
 Explain: _____
12. Does the patient have any special problems not listed? YES NO
 Explain: _____
13. Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? YES NO
 If yes, antibiotic name and method: _____

DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- | YES | NO | YES | NO | YES | NO |
|--------------------------|---|--------------------------|---|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> AIDS or H.I.V. Positive | <input type="checkbox"/> | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Angina | <input type="checkbox"/> | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Attack (coronary) | <input type="checkbox"/> | <input type="checkbox"/> Herpes (oral-cold sores) | <input type="checkbox"/> | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> Inflammatory Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> Jaw Clicking |
| <input type="checkbox"/> | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Surgery/Date _____ | <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> Ulcers | <input type="checkbox"/> | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Prosthetic (artificial) Joint | <input type="checkbox"/> | <input type="checkbox"/> Anemia | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> X-Ray/Radiation (cancer) Therapy | <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Respiratory Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy | | |
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | | |
| <input type="checkbox"/> | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Fainting Spells | | |

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING FROM INADEQUATE INFORMATION OR INFORMATION NOT DISCLOSED.

Signature of parent or guardian

 Signature of Orthodontist

Today's Date _____
 Update _____ Initial _____
 Update _____ Initial _____
 Update _____ Initial _____
 Update _____ Initial _____

NOTES:

