(Child)

Southern Minnesota Orthodontics, P.A.

DRS. KANYUSIK, WIEMERS, SWANSON & VAUBEL

Patient # ______________________

Date: ______________________

Please assist us by completing the following questions:

Patient's Name: Sex: Age: Birthdate:

Address: City: Zip: Referred by:

Email Address: Home #:

School: Grade:

Father's Name: Occupation: Dad Cell #:

Father's Social Security #: Father's Employer: Work Phone:

Mother's Name: Occupation: Mom Cell #:

Mother's Social Security #: Mother's Employer: Work Phone:

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

#Sisters #Brothers 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 **Dental** Insurance Co: Group/Plan #: Orthodontic Coverage: ☐Yes ☐No

Insurance Co. Address: City: State: Zip:

Subscriber's Name: Subscriber's ID #: Subscriber's Birthdate:

Secondary **Dental** Insurance Co: Group/Plan #: Orthodontic Coverage: ☐Yes ☐No

Insurance Co. Address: City: State: Zip:

Subscriber's Name: Subscriber's ID #: Subscriber's Birthdate:

I understand I am responsible for any balance not covered by insurance.

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:

DOES THE PATIENT HAVE NOW OR HAS HE/SHE EVER HAD ANY OF THE FOLLOWING:

YES	NO	
☐	☐	Endocarditis
☐	☐	Heart Condition
☐	☐	Heart Pacemaker
☐	☐	Heart Angina
☐	☐	Heart Attack (coronary)
☐	☐	Mitral Valve Prolapse
☐	☐	Congenital Heart Disease
☐	☐	Artificial Heart Valve
☐	☐	Heart Surgery/Date ____________
☐	☐	Heart Murmur
☐	☐	Rheumatic Fever
☐	☐	Prosthetic (artificial) Joint
☐	☐	X-Ray/Radiation (cancer) Therapy
☐	☐	Respiratory Lung Disease
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure

YES	NO	
☐	☐	Hepatitis
☐	☐	Tuberculosis
☐	☐	AIDS or H.I.V. Positive
☐	☐	Venereal Disease
☐	☐	Herpes (oral-cold sores)
☐	☐	Blood Disorder
☐	☐	Inflammatory Rheumatism
☐	☐	Arthritis
☐	☐	Diabetes
☐	☐	Ulcers
☐	☐	Stroke
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Epilepsy
☐	☐	Glaucoma
☐	☐	Fainting Spells

YES	NO	
☐	☐	Kidney Trouble
☐	☐	Liver Disease
☐	☐	Psychiatric Treatment
☐	☐	Drug Addiction
☐	☐	Headaches
☐	☐	Earaches
☐	☐	Jaw Clicking
☐	☐	Allergies
☐	☐	Jaw Pain
☐	☐	Tonsillitis
☐	☐	Emotional Problems
☐	☐	Cancer
☐	☐	Other ______________

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. I UNDERSTAND THAT THE VISUAL EXAMINATION IS FREE OF CHARGE, HOWEVER THERE WILL BE A CHARGE FOR ANY DIAGNOSTIC RECORDS DEEMED NECESSARY.

Signature of parent or guardian

____

Signature of Orthodontist

____

Today's Date ______________________________

Update ______________________________ Initial ________

Update ______________________________ Initial ________

Update ______________________________ Initial ________

Update ______________________________ Initial ________

NOTES:

____

____

____

____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.