UNDER 18

WELCOME TO OUR OFFICE

PATIENT INFORMATION AND HEALTH SURVEY

UNDER 18

Welcome to our office. Please fill out both sides of form.

Patient's Name ______ Age ______ Birth date ______ Sex M F
Street Address ______ City ______ State ______ Zip Code ______
Home Phone ______ Cell Phone (adult) ______
Email (adult) ______ School ______ Grade ______

Person responsible for financial matters

Name(s) ______ Birth date ______ Social Security No. ______
Street Address ______ City ______ State ______ Zip Code ______
Home Phone ______ Business Phone ______
Place of Employment ______ Email ______
Driver's License # ______

	Family Dentist	**Family Physician**
Name	______	______
Address	______	______
City, State	______	______

Who may we thank for referring you to our office? ______
How else have you heard about us? ______

FAMILY AND PATIENT INFORMATION

Father's Name ______ Living? No❒ Yes❒ Occupation ______
Mother's Name ______ Living? No❒ Yes❒ Occupation ______
Parents Marital Status ______ Patient Living with: M F Both Other ______
Sibling(s) (name & ages) ______
Reason for orthodontic consultation? ______
Has anyone in your family had a similar problem? No❒ Yes❒
Is patient self-conscious about his/her teeth? No❒ Yes❒
Patient's attitude toward orthodontic treatment ______
______

INSURANCE INFORMATION

Are you covered by insurance for orthodontic treatment? No❒ Yes❒
Insured Name ______ Insured Date of Birth ______
Insured Employer ______ Insured SSN# ______
Insurance Company ______ Insurance ID# ______
Insurance Verification Phone Number ______
Insured Claims Address ______

MEDICAL HISTORY – Has the patient ever had any of the following? (please circle)

AIDS	Bleeding	Emotional Problems	Head or Face Injuries	Oral Ulcer
Allergy	Bone Loss/Disorders	Epilepsy/Seizures	Hepatitis	Previous Surgery
Anemia	Cold Sores	Growth Problems	Herpes	Rheumatic Fever
Arthritis	Diabetes	Hearing Problems	Kidney Disease	Thyroid Problems
Asthma	Endocrine Problems	Heart Condition	Lung Disease	Other (describe below)

Comments ______
Has the patient been under the care of a physician during the past two years, other than for routine examinations? No❒ Yes❒
Condition ______ Date of last medical exam ______
Do you require antibiotic premedication for dental procedures? No❒ Yes❒
Present drugs or medications ______

Birth Defects: ____________________

Patient's Height: ____________________

RESPIRATORY HISTORY

- Do you have allergies to:
  - Drugs: ____________________
  - Food: ____________________
  - Seasonal Grasses: ____________________
  - Other: ____________________
- Breathe through mouth? Seldom❐ Sometimes❐ Usually❐
- Snore when sleeping? No❐ Yes❐
- Have frequent colds? No❐ Yes❐
- Have frequent "Stuffy Nose?" No❐ Yes❐
- Have frequent sore throat or tonsillitis? No❐ Yes❐
- Have difficulty chewing or swallowing? No❐ Yes❐

Have you received medical treatment from an allergist or ear, nose, and throat specialist? No❐ Yes❐

If yes: When:____________________ By Whom:____________________

Nasal Surgery❐ Tonsils removed❐ Adenoids removed❐

DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY

Has the patient had any unusual dental experiences? No❐ Yes❐

Specify ____________________

Any injuries to the mouth, teeth or face? No❐ Yes❐

Specify ____________________

Date of last dental checkup ____________________Were the patient's teeth cleaned? No❐ Yes❐

Has the patient had an orthodontic consult or treatment? No❐ Yes❐

If yes, please indicate when and where____________________

Does the patient have Headaches?❐ Neck Pain?❐ Jaw Pain?❐ Ear Pain?❐ Face Pain?❐ Eye Pain?❐ Other?❐

Which side hurts? Right?❐ Left?❐ Both?❐

How long has the patient had these symptoms?

Years____________ Days____________ Months____________

Is the pain constant?❐ Aching?❐ Shooting?❐ Burning?❐ Stabbing?❐ Electrical?❐ Other?❐

Worse in the afternoon?❐ Worse in the morning?❐ Does it hurt to chew?❐ Does it hurt to open wide?❐

Does the patient's jaw ever make a popping noise?❐ Clicking?❐ Grinding?❐ Other?❐

Has the patient's jaw ever "locked" or slipped out of place? No❐ Yes❐

Does the patient ever clench or grind his/her teeth? No❐ Yes❐

During the day?❐ During the night?❐

Does the patient have problems with his/her ears?❐ Hearing?❐ Dizziness?❐ Other?❐

Is it difficult to swallow?❐ Painful?❐

Are the teeth sore or sensitive? No❐ Yes❐

INDICATE HABITS, PAST OR PRESENT

Thumb or Finger Sucking❐ Tongue Thrust (reverse swallowing)❐ Lip Biting❐ Nail Biting❐

Poor speech habits❐ Other❐

Additional comments____________________

____

Parent/Guardian Signature____________________ Date____________________

Doctor Signature____________________ Date____________________

Welcome to Bernstein Orthodontics!

We look forward to treating you.

Please answer the questions below so **we can get to know you!**

My name is: ____________________________

The name of my school is: __________________

____

What is your favorite food or restaurant?

____

What groups/ activites do you participate in you community?____________________________________

____

What is your favorite TV show?_______________

____

What clubs/programs are you involved in at your school?_______________________________

____

What college are you planning on attending?

____

What career do you want to pursue?

____

What are your hobbies?____________________

____

What is your favorite type of music?_________

____

What is your favorite singer and/or band?____

____

Do you have a pet?____________________________

What is your pet's name?______________________

What is your favorite animal?_________________