CHILD ORTHODONTIC PATIENT QUESTIONNAIRE

Patient's name:____ Preferred name:_________________
Last First MI
Date of Birth:________________________ Sex: M F
Name of School:____ Grade level:______________
Hobbies/Interests:____

Name of responsible party:____
Address: Street:____ City:___________________
E-mail address:____________________________________ Home Telephone: (___)_____________
Work Telephone:(____)___________________ Cell Phone: (____)___________________________
Why are you and your child seeking orthodontic treatment? (Please be as specific as possible):
____
Who may we thank for referring you to our office? _______________________________________

FAMILY STATUS
Father's name:____ Cell phone: (___)___________
Occupation:_____________________________ Employer:_____________________________________
Work Phone(____)____________
Mother's name:____ Cell phone: (___)___________
Occupation:_____________________________ Employer:_____________________________________
Work Phone(____)____________
Marital Status of parents:______________________________ Is the patient adopted? Yes No

INSURANCE INFORMATION Will you be using dental insurance? Yes No
Insurance company:____________________________________ Group Number:_________________
Telephone Number: (_____)________________________
Name of Subscriber: ________________________________ Employer:______________________
Subscriber's Date of Birth_______________________________ SS#_____________________________

DENTAL HISTORY
General Dentist:____ Phone: (_____)_______________
Address:____
Date of last dental examination: _____________________________

Has this patient had a previous orthodontic consultation? Yes No Where?______________

Has the patient ever had trauma/damage to the teeth, jaws, or gums? Yes No

MEDICAL HISTORY

Family Physician:_______________________________________

Is the patient currently under a physician's care? Yes No
If yes, please explain ____
Is the patient taking any medicine at this time? Yes No
If yes, please list ____
Is the patient allergic to any medications? Yes No If yes, please list ____________________
Does the patient have any other allergies? Yes No If yes, please list ___________________
Does the patient need to be premedicated (with antibiotics) for routine dental procedures? Yes No
If yes, please specify and give reason for this need: ____________________________________
Has the patient ever been hospitalized? Yes No If yes, please explain
____
Females: Is the patient pregnant? Yes No

Does the patient have or has the patient ever had any of the following?

Yes	No		Yes	No		Yes	No	
◻	◻	AIDS/HIV+	◻	◻	Cold Sores	◻	◻	Injury to head
◻	◻	Anemia	◻	◻	Rheumatic Fever	◻	◻	Kidney Disease
◻	◻	Arthritis	◻	◻	Diabetes	◻	◻	Lung Disease
◻	◻	Asthma	◻	◻	Epilepsy/Seizures	◻	◻	Previous Surgery
◻	◻	Oral Ulcers	◻	◻	Hearing Problem	◻	◻	Psychological Therapy
◻	◻	Birth Defects	◻	◻	Heart Condition	◻	◻	Radiation or cancer therapy
◻	◻	Bleeding Disorder	◻	◻	Speech Therapy	◻	◻	Tonsils/Adenoid Surgery
◻	◻	Cerebral Palsy	◻	◻	Hepatitis	◻	◻	Injury to face/teeth/gums

Does the patient have any disease, condition, or problem not listed above? Please explain:
____
____

DOES/DID THE PATIENT:

Grind his/her teeth at night? Yes No   Brush his/her teeth ◻ Often ◻ Occasionally ◻ Reluctantly

Suck thumb, finger, pacifier? Yes No   If yes, what age was the habit discontinued?_____________

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT

Is the patient aware of the problem? Yes No
The patient's interest in having treatment is: ◻ Excited ◻ Willing if necessary ◻ Reluctant

BEHAVIOR ASSESMENT

Personality (check any that apply):
◻ Calm ◻ Nervous ◻ Quiet ◻ Shy ◻ Outgoing ◻ Uncooperative ◻ Cooperative ◻ Confident
◻ Afraid ◻ Emotional disturbance

Thanks for your help. We're excited to get to know you better!

Signature of the person completing this form:_______________________________________

Relationship to the patient:_________________________Today's Date:________________