LAKEWOOD PARK ORTHODONTICS

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's Name: Last First Middle In.

Address: Street City State Zip

Birthdate (MM/DD/YYYY) SSN

School Sports/Hobbies

RESPONSIBLE PARTY INFORMATION

Name: Last First Middle In.

Residence: Street City State Zip

How long at this address? Home Phone Cell Phone Work Phone

Mailing Address: Street City State Zip

Employer Occupation No. Years Employed

Relationship to Patient: Birthdate (MM/DD/YYYY) SSN

Name: Last First Middle In.

Relationship to Patient Birthdate (MM/DD/YYYY) SSN

Residence: Street City State ZIp

How long at this address? Home Phone Cell Phone Work Phone

How did you hear about our office?

DENTAL INSURANCE INFORMATION

Insurance Company Subscriber's Name

Subscriber's ID No. Subscriber's Group No. Subscriber's Local No.

Insurance Co. Address Ins. Co. Phone No.

Does the patient have dual coverage? *(Circle)* **NO** **YES** *If yes, please fill out the below:*

Insurance Company Subscriber's Name (If Different than Above)

Subscriber's ID No. Subscriber's Group No. Subscriber's Local No.

Insurance Co. Address Ins. Co. Phone No.

EMERGENCY INFORMATION

Emergency Contact Name Phone No.

Address: Street City State Zip

Parent/Guardian Signature:_____ Date:_____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____ Phone No. _____

Address: Street _____ City _____ State _____ Zip _____

Please Circle YES or NO			*If YES, please fill in details*
Is the patient taking any medication?	NO	YES	
Is the patient allergic to any medication?	NO	YES	
Does the patient have a history of a major illness?	NO	YES	
Has the patient had any operations?	NO	YES	
Has the patient been involved in a serious accident?	NO	YES	
Have you seen a physician in the last 12 months?	NO	YES	
Is the patient allergic to latex?	NO	YES	
Is the patient allergic to any metals?	NO	YES	
Female Patients Only			
Has menstruation started?	NO	YES	
Is the patient pregnant?	NO	YES	

Circle any of the medical conditions below which you have had or currently have:

Abnormal Bleeding	Hemophilia	Diabetes	Hepatitis	Asthma
Prolonged Bleeding	Anemia	Arthritis	Dizziness	Pneumonia
Herpes	High Blood Pressure	Epilepsy	Hearing Impaired	Hayfever
Radiation/Chemotherapy	Tumor or Cancer	Heart Murmur	Rheumatic Fever	Tuberculosis
HIV/AIDS	Heart Problems	Liver Problems	Kidney Problems	Bone Disorders
Nervous Disorders	Congenital Heart Defect	Gastrointestinal Disorders		

Are there any medical conditions not listed of which you feel we should be aware?

DENTAL HISTORY

General Dentist _____ Date of Last Visit _____ Phone No. _____

Address: Street _____ City _____ State _____ Zip _____

What is the main concern with the patient's teeth?

Please Circle YES or NO			*If YES, please fill in details*
Is the patient presently in any dental pain?	NO	YES	
Has the patient ever lost or chipped any teeth?	NO	YES	
Have there ever been any injuries to face, mouth, or teeth?	NO	YES	
Is the patient's mouth sensitive to temperature/pressure?	NO	YES	Where?
Do the patient's gums bleed when brushing?	NO	YES	
Does the patient have any type of thumb or tongue habit?	NO	YES	
Is the patient a mouth breather?	NO	YES	
Has the patient ever seen an orthodontist?	NO	YES	Who and when?
What is the patient's attitude toward receiving orthodontic treatment?			
Has anyone in the family received orthodontic treatment?	NO	YES	
Do the patient's teeth or jaws ever feel uncomfortable first thing in the morning?	NO	YES	
Does the patient experience jaw clicking or popping?	NO	YES	
Does the patient clench or grind his/her teeth during the day?	NO	YES	
Has the patient ever experienced chronic ringing in the ears?	NO	YES	
Are you aware that some appointments will be during school hours?	NO	YES	

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged 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. Hughes** to perform a complete orthodontic evaluation.

Parent/Guardian Signature:_____ Date:_____ Dr.'s Initials_____