coleman ORTHODONTICS

PATIENT INFORMATION

A B C

Name _____ Sex ____ Phone _____ Birthday _____ Age _____

Address _____ City _____ State _____ Zip _____

Primary Email _____

RESPONSIBLE PARTY INFORMATION

FATHER or SELF or GUARDIAN INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

How long at this address _____

Previous Address (if less than 3 yrs) _____

Home Phone _____ Work/Cell _____

Birthday _____ Age ____ Sex ___ Marital Status ___

S.S. # _____ Email_____

EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

Employer City _____ State ___ Zip _____

Occupation _____ # Yrs. Employed_____

Orthodontic Coverage? Yes _____ No _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State ___ Zip _____

Insurance Phone _____ Ext _____

Group # _____

MOTHER or SPOUSE INFORMATION

Name _____

Address _____

City _____ State ____ Zip _____

How long at this address _____

Previous Address (if less than 3 years) _____

Home Phone _____ Work/Cell _____

Birthday_____ Age ___ Sex ___ Marital Status ___

S.S. # _____ Email_____

EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

Employer City _____ State ___ Zip _____

Occupation _____ # Yrs. Employed_____

Orthodontic Coverage? Yes _____ No _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State ___ Zip _____

Insurance Phone _____ Ext _____

Group # _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship_____ Phone _____

Address_____

OTHER INFORMATION

Who is the responsible party? _____

Other children _____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

Sports or Hobbies _____

Dentist Name _____

Who may we thank for referring you? _____

_____

Physician Name _____

School Name _____ Grade _____

MEDICAL INFORMATION

Yes	No		Yes	No	
___	___	Any heart disease	___	___	Any problems with wounds healing
___	___	Any respiratory disease	___	___	Has the patient reached puberty
___	___	Any blood disease	___	___	Heart murmur
___	___	Any thyroid disease	___	___	Mitral valve prolapse
___	___	Any kidney disease	___	___	Mononucleosis
___	___	H.I.V. Positive	___	___	Hepatitis
___	___	Any intestinal disease	___	___	Yellow jaundice
___	___	Any bone disease	___	___	Anemia
___	___	Allergic to anything	___	___	Epilepsy
___	___	Any endocrine problems	___	___	Latex allergy
___	___	Any prolonged bleeding	___	___	Fever blisters
___	___	Rheumatic/Yellow/Scarlet fever	___	___	Tuberculosis
___	___	Acquired Immune Deficiency Syndrome	___	___	Diabetes
___	___	Is patient under medical care	___	___	Hemophilia
___	___	Any history of fainting or dizziness	___	___	Asthma or hayfever
___	___	Any nervous/emotional problems	___	___	Any liver disease
___	___	Does the patient smoke	___	___	Rheumatism or arthritis
___	___	Is the patient pregnant	___	___	Any tumors or cancer
___	___	Is the patient in good health	List any medications the patient is taking _____		
___	___	Any high/low blood pressure	List any problems not mentioned above that we should know about _____		
___	___	Is height and weight normal for age	_____		

DENTAL HISTORY

Yes	No	
___	___	Any pain, clicking or discomfort in or near ears
___	___	Has the mouth, face or teeth been injured in an accident
___	___	Have you been informed of missing or extra permanent teeth
___	___	Are you aware of any " gum " problems?
___	___	Have the patient' s tonsils or adenoids been removed?
___	___	Do you feel the patient can benefit from orthodontic treatment?
___	___	Is the patient happy with their smile?
___	___	Does the patient want to improve their smile?
___	___	Would the patient mind wearing " braces" ?

Does the patient have/had any habits?

Yes	No	
___	___	Cheek, tongue, lip chewing
___	___	Thumb sucking
___	___	Mouth breathing
___	___	Fingernail biting
___	___	Clenching teeth
___	___	Tongue thrusting
___	___	Grinding teeth
___	___	Speech problems

Date of last dental cleaning _____ Has the patient had a panoramic x-ray in the last six months? _____

Have other members of the family had orthodontic treatment? _____

In your own words, what is the orthodontic problem? _____

What would you like orthodontic treatment to accomplish? _____

I understand that where appropriate, credit bureau reports may be obtained.

Parent Signature _____ Date _____ Patient Signature _____