SW Ortho
CREATING BEAUTIFUL SMILES
Southwest Orthodontic Associates

PATIENT UNDER 18

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City Zip

Nickname _____ ❑ Male ❑ Female ❑ Prefer not to say Birthdate _____ Age _____

School _____ **Sports / Hobbies** _____

Parent / Guardian Name _____
Mother Father

Parents Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Siblings living at home _____ **Family members treated by us** _____

Patient's Dentist _____ Last Dental Visit _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY

Name _____
Last First Middle

Address _____
Street City Zip

Work Phone _____ Cell / Other Phone _____

Email Address _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

DENTAL INSURANCE

PRIMARY

Insured's Name _____ Insured's Social Security # _____

Insured's Employer _____

Insured Birthdate _____ Payor ID # _____ Group # _____

Insurance Company _____ ID # _____

Insurance Company Address _____ Phone _____

Do you have dual coverage? Yes _____ No _____ If yes, complete secondary section

SECONDARY

Insurer's Name _____ Insurer's Social Security # _____

Insured's Employer _____

Insurer's Birthdate _____ Payor ID # _____

Insurance Company _____ Group # _____ ID # _____

Insurance Company Address _____ Phone _____

Insured Relationship to Patient _____

EMERGENCY CONTACT

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

South Side Press F12014-E

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Please circle Yes or No

Height of Parents **Mom** _____ **Dad** _____

Does the patient have any allergies? Yes No If yes, list them _____

History of a major illness? _____

Has patient seen an ENT? Yes No **Tonsils / Admoids removed? Yes No**

Has patient had any other surgeries? Yes No If yes, list them _____

Ever been in a serious accident? Yes No If yes, list them _____

Has patient seen a physician in the last 12 months? Yes No Why? _____

History of sleep apnea in the family? Yes No **If yes, relationship to patient?** _____

Has the child entered puberty? Yes No

Female Patients Only: **Are you pregnant? Yes No**

Does your child have any specific learning and /or communication needs? _____

Circle any of the medical conditions below that you have had or currently have.

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

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

What concerns you most about your childs teeth? _____

Is patient a mouth breather? Yes No

Have there been any injuries to face, mouth, or teeth? Yes No

Any type of thumb or finger habit? Yes No

Do teeth or jaws ever feel uncomfortable first thing in the morning? Yes No

Experience jaw clicking or popping? Yes No

Aware of any clenching or grinding during the day? Yes No

Experience "tension" headaches? Yes No

Is patient self-conscious or sensitive about his/her teeth? Yes No

What is childs attitude toward receiving orthodontic treatment? _____

Are you aware that some appointments will be durning school hours? Yes No

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. _____ to perform a complete orthodontic evaluation.

Signature: _____ Date: _____