Lakeview Orthodontics

Date_____ Case #_____

Patient's Name _____ Age_____ Birth Date_____ Sex _____
Last First Middle Preferred Name

Address_____ City_____ State_____ Zip _____

Telephone_____ Cell_____ Whom may we thank for referring you? _____

School_____ Grade_____ Email: _____

Patient's Dentist_____ Last Visit_____ Physician _____

Father's Name_____ Address _____ Zip_____

Employed by _____ Business Phone _____

Business Address _____ Soc. Sec. # _____

Driver's License # _____ Date of Birth _____

Mother's Name_____ Address _____ Zip_____

Employed by _____ Business Phone _____

Business Address _____ Soc. Sec. # _____

Driver's License # _____ Date of Birth _____

Is patient adopted or Foster? Yes ( ) No ( )

Person financially responsible for this treatment _____

Address _____

Names and ages of other children _____

Main complaint (in patient's or parent's own words) _____

MEDICAL HISTORY

Please check any of the following conditions or problems patient has experienced

Anemia	( )	Emotional	( )	Fainting or dizziness	( )	Mumps	( )
Asthma	( )	Endocrine (Hormone)	( )	Hearing	( )	Rheumatic fever	( )
Bone (fracture)	( )	Epilepsy	( )	Heart	( )	Speech	( )
Convulsions	( )	Excessive bleeding	( )	Kidney	( )	Tuberculosis	( )
Diabetes	( )	Eye	( )	Liver	( )	Hepatitis	( )
						ADD	( )
						ADHD	( )

Other _____

Have you or any of your family members been diagnosed as being HIV positive?

Does patient have frequent Colds_____ Sore throats_____ Ear Infections_____ or have Tubes in ears _____

Have tonsils and adenoids been removed?_____ If so, what age_____

List any drugs or medications now being taken:_____ Give reasons:_____

List any allergies or drug sensitivity:_____

Has the patient reached puberty?

Girls – Has she started menstruation? .....Yes ( ) No ( ) Age started _____

Boys – Has his voice changed? .....Yes ( ) No ( ) At what age _____

DENTAL HISTORY

Did patient have decayed teeth by age four? ..... Yes ( ) No ( )

Does patient have decayed teeth now? ..... Yes ( ) No ( )

Have there been any injuries to the face, mouth or teeth? ..... Yes ( ) No ( )

Has the patient ever sucked a thumb or finger? Until what age? ..... Yes ( ) No ( )

Has patient ever sucked a lip or tongue at night? ..... Yes ( ) No ( )

Is patient's oral hygiene: Poor_____ Fair_____ Excellent_____ Sporadic_____

Have you been informed of any missing or extra permanent teeth? ..... Yes ( ) No ( )

Has an orthodontist been consulted previously? ..... Yes ( ) No ( )

Does the patient's face resemble: Father_____ Mother_____ Neither_____

Has either parent had an orthodontic problem? ..... Yes ( ) No ( )

Was either parent treated for orthodontic problems? ..... Yes ( ) No ( )

If yes, describe briefly. _____

Does patient see dentist for regular dental treatment? ..... Yes ( ) No ( ) How often?_____

Does PATIENT desire orthodontic treatment? ..... Yes ( ) No ( )

Mother's Height_____ Father's Height_____

REMARKS _____

Signature of parent or guardian _____

INSURANCE: Do you have Dental Insurance and do you plan to file? _____

Insured Name:_____ DOB_____ Policy #_____