

Lakeview Orthodontics

Date _____ Chart # _____

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 _____ Cell Phone Carrier _____ 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

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

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

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

List any allergies or drug sensitivity: _____

DENTAL HISTORY

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 ()

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 # _____