Patient's Full Name _____

Nickname or Preferred Name _____

Date of Birth _____ Age _____ Height _____ Weight _____ Gender ☐ M ☐ F

Address _____ City _____ State _____ Zip_____

Home Phone _____ Patient's School _____ Patient's Grade _____

Patient's Dentist _____ Patient's Physician _____

Mother's Name _____ Date of Birth _____

Occupation _____ Employed by _____

Business Phone _____ Cell Phone _____

Name of Dental Insurance Company _____

Social Security # _____ E-mail _____

Father's Name_____ Date of Birth _____

Occupation _____ Employed by _____

Business Phone _____ Cell Phone _____

Name of Dental Insurance Company _____

Social Security # _____ E-mail _____

In case of emergency, who should be notified? _____

Relationship to patient_____Phone_____

Names and ages of other children in the family _____

Whom may we thank for referring you? _____

Who is financially responsible for this account? (please provide full name)_____

Relation to patient_____

Reason for a consultation? _____

DENTAL HISTORY

Date of last dental exam/cleaning _____

Yes No Is the patient currently in any dental or medical pain?_____

Yes No Did the patient have any of the following habits? Finger/Thumb-Sucking Lip-Sucking Lip-Biting Pacifier

Yes No Did habit occur past the age of four?_____

Yes No Is the habit is still present?_____

Yes No Have there been injuries to the face, mouth, gums or teeth? _____

Yes No Has the patient ever lost or chipped any teeth?_____

Yes No Is any part of the patient's mouth sensitive to pressure or temperature?_____

Yes No Do the patient's gums bleed when he/she brushes? _____

Yes No Do the patient's teeth or jaws ever feel uncomfortable when awaking in the morning?_____

Yes No Are you aware of the patient's jaw clicking or popping?_____

Yes No Are you aware of the patient clenching his/her teeth during the day?_____

Yes No Does the patient grind his/her teeth?_____

Yes No Are you aware that some appointments will be during school/work hours?_____

Yes No Has an orthodontist been consulted previously? _____

Yes No Did the patient have previous orthodontic treatment? _____

Yes No Has either parent or another member of the family had orthodontic treatment? _____
Yes No Is the patient aware of a problem? _____

MEDICAL HISTORY

Date of last physical_____
Yes No Is the patient in good health?_____
Yes No Is there a history of a major illness?_____
Yes No Has the patient ever had any major operations?_____
Yes No Has the patient ever been involved in a serious accident?_____
Yes No Is the patient currently under the care of a physician? Please state reason or condition_____
Yes No Does the patient have any drug allergies or had an adverse reaction to any medication?_____
Yes No Is the patient taking any drugs/medications at this time? (Please list)_____
_____
Yes No Does the patient need to be pre-medicated (antibiotics) for routine dental procedures?_____

Female patients only:

Yes No Has the patient started menstruation?
Yes No Do you suspect that the patient is pregnant?

Male patients only:

Yes No Has the patient's voice changed?
Yes No Has facial hair growth began?

Circle any of the conditions below that the patient has had or currently has.

-ADHD	-Chronic Ringing of Ears	-Herpes	-Pneumonia
-Anemia	-Circulatory Problems	-Hepatitis	-Psychiatric Care
-Arthritis	-Cold Sores	-High Blood Pressure	-Recent Weight Loss
-Artificial Heart Valves	-Diabetes	-HIV/AIDS	-Rheumatic Fever
-Asthma or Hayfever	-Dizziness	-Kidney Problems	-Sinus Problems
-Autoimmune Disease	-Ear Infections	-Low Blood Pressure	-Sore Throats
-Back Problems	-Epilepsy	-Lung Disease	-Special Diet
-Bipolar	-Gastrointestinal Disorders	-Nervous Disorders	-Stroke
-Blood Disorders		-Mouth Breathing	-Swollen Neck Glands
-Bone Disorders	-General Allergies	-Oral Ulcers	-Tuberculosis
-Cancer	-Headaches	-Radiation/ Chemotherapy	-Tumor or Cancer
-Chemical Dependency	-Heart Problems		-Venereal Disease
-Chronic Diarrhea	-Hemophilia	-Prolonged Bleeding	-Other_____

Is there anything else we should know about the patient's medical history? _____

The patient's interest in having treatment is: ☐ Wants treatment ☐ Willing if necessary ☐ Unwilling

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 and I also understand that my child's diagnostic records and 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 child's medical or dental history. I will not hold Dr. Lembck or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form. In addition, I authorize Dr. Lembck to perform a complete orthodontic evaluation. I understand that where appropriate, credit bureau reports may be obtained.

Date_____ Parent's Signature_____