ORTHODONTIC PATIENT EVALUTAION

Today's Date_____

Patient's Name _____ Sex: M_____ F_____ Birthdate_____ Age_____
Parent's Names (Mother)_____ (Father)_____
Parents are married_____ separated_____ divorced_____ widowed_____
Responsible Party (if not parents)_____ Cell Phone_____
Home address_____ Home Phone_____
Business address (Mother)_____ Business Phone_____
(Father)_____ Business Phone_____
Do you have insurance or a health program which may cover orthodontics?_____ SS#_____
Who referred you to our office?_____
Family Dentist_____ Approx. date of last exam _____
Family Physician_____ Approx. date of last exam _____
Quality of patient's school work A_____ B_____ C_____ D_____ F_____
How often is child absent from school? Never_____ Seldom_____ Frequent_____
Patient's hobbies and interests_____
How cooperative is patient? Very_____ Not Very _____ Only when motivated_____
What is the orthodontic problem as you see it?_____
Does anyone in the family have similar dental or facial conditions?_____ Who?_____
Has anyone in the family had orthodontic treatment?_____ Who?_____
Name of orthodontist_____
Indicate patient's concern for correction of orthodontic problem:
Very concerned_____ concerned_____ indifferent_____ opposed_____
Indicate parent's concern for correction of child's orthodontic problem:
Very concerned_____ concerned_____ indifferent_____ opposed_____

Medical History:

Yes	No		
( )	( )	Have tonsils or adenoids been removed? At what age?_____	
( )	( )	Is patient now taking any medication? If so, what_____	
( )	( )	Allergy to any drugs? Penicillin_____ Aspirin_____ Local Anesthesia_____ Other____	
( )	( )	Frequent nasal obstruction, earaches or sore throat?	
( )	( )	Allergies: Asthma_____ Hayfever_____ Hives_____ Skin Rash_____ Other_____	
( )	( )	Any accidents or trauma to face or teeth? When?_____	
( )	( )	Frequent headaches and/or jaw pains?	
( )	( )	Has there been an significant increase in height in the past six months to a year?	
( )	( )	Female patient: Has menstruation begun? If so, when_____	
( )	( )	Heart problems? Explain_____	
( )	( )	Rheumatic fever or rheumatic heart disease	
( )	( )	Hepatitis	
( )	( )	Anemia	Does patient have epilepsy or seizures?_____
( )	( )	Kidney Disease	Controlled_____ Uncontrolled_____
( )	( )	Prolonged bleeding	
( )	( )	High blood pressure	Has patient had any difficulty with speech?_____
( )	( )	Blood transfusions	If so, was therapy involved?_____
( )	( )	Diabetes	Therapist's name_____
( )	( )	Emotional problems	
( )	( )	Is patient now under medical care? Explain_____	

Habits:

( )	( )	Thumb or finger sucking	( )	( )	mouth breathing
( )	( )	Lip or cheek biting	( )	( )	tongue thrusting
( )	( )	Grinding teeth			

Parent's Signature_____

(Please feel free to use additional sheets as necessary to respond to any question)