Passamano Orthodontics

Date _____

PATIENT INFORMATION / HEALTH HISTORY

(Child Patient)

Patient's name _____ Birthdate _____ Age _____

Nickname _____ Sex □ M □ F Who can we thank for referring you? _____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone _____ Cell Phone Provider _____

Mother's name _____ Phone: _____ □ Home □ Cell □ Work

Address (if different from patient's) _____

Occupation _____ Employer's Name & Location: _____

Father's name _____ Phone _____ □ Home □ Cell □ Work

Address (if different from patient's) _____

Occupation _____ Employer's Name & Location _____

□ Mother's □ Father's □ Both **E-Mail Address(es)** _____

Responsible Parties _____ □ Married □ Remarried □ Divorced □ Single

Orthodontic insurance: □ Yes □ No □ Unknown Name of Dental Insurance: _____

Primary Policy Holder Name _____ Social Security # or Member ID# _____ DOB _____ (for verification of coverage)

Patient's Dentist _____ Patient's physician _____

What is your primary concern about your child's teeth? _____

_____

How soon would you like to start treatment? _____

Is your child interested in having his/her teeth straightened? _____

Other orthodontic consultation and/or treatment: _____

When _____ Where _____

School _____ Grade _____ Hobbies _____

Activities/Sports _____

Please complete the other side

MEDICAL HISTORY - Please Check if the Patient Had or Has the Following:

___ Allergies
- ___ Penicillin
- ___ Local anesthetic
- ___ Medication or drugs
- ___ Nickel
- ___ Others

___ Anemia
___ Asthma
___ Blood disease
___ Abnormal blood pressure
___ Colds Frequent?
___ Sinus trouble
___ Diabetes
___ Epilepsy
___ Convulsions
___ Prolonged recent illness
___ Heart disease/defect
___ Pregnant?
___ Hepatitis
___ Headaches Often?
___ Tonsils removed Age ___
___ Adenoids removed Age ___
___ Liver or kidney disease
___ Rheumatic fever
___ Scarlet fever
___ Sore throats Frequent?
___ Earaches/infections Frequent?
___ Have you ever fainted?
___ Positive for HIV antibodies
___ Other medical condition ...

_____

DENTAL HISTORY - Please Fill in the Blank Where Applicable:

Thumb sucking until Age _____ Which thumb? _____

Finger sucking until Age _____ Which finger(s)? _____

Nail or Lip biting _____ **Teeth grinding/Clenching** _____

Snoring / Sleep Apnea _____ **Mouth breathing** _____

Sleep with Lips Parted _____ Extractions / Surgery _____

Speech Therapy _____ Other? _____

Injuries to Face, Jaw, Head, Teeth? _____

_____

Please Evaluate the Following as Good, Fair, or Poor:

Chewing _____ Sleep _____ # Hours _____

Tooth Brushing _____ Cooperation _____

_____
Signature

In the event that any information on this form is changed, it is your responsibility notify us immediately.