dobbs | orthodontics

Date ____________________

Patient's Name ______________________________ Age ______ Birthdate ____________

Nickname ____________________ ☐Male ☐Female SS# ____________________

Home Address ____

Home Phone ______________ Cell Phone ______________ Email ______________

School ______________ Grade ______________

How did you hear about our office? ☐ Dentist ☐ Family/Friend ☐ Internet ☐ Other ____________

Have we treated another member of your family? Yes No If YES, Name ____________

Custodial Parent(s) Name(s) ______________________________________

Patient Lives With ☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Grandparent(s) ☐Other

Father's Full Name ☐Mr. ☐Dr. ______________________________________

Occupation ______________________________ Email ______________

Address (if different) ______________________________________

Home Phone (if different) ______________ Cell ______________ Work ______________

Mother's Full Name ☐ Mrs. ☐ Ms. ☐ Dr. ______________________________

Occupation ______________________________ Email ______________

Address (if different) ______________________________________

Home Phone (if different) ______________ Cell ______________ Work ______________

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ______________________________

Address (if different) ______________________________________

Home Phone (if different) ______________ Cell ______________ Work ______________

Social Security # ______________ Employer ______________

Who will be responsible for bringing the patient to orthodontic appointments? ______________

DENTAL INSURANCE

Primary Policy Holder's Full Name ______________________________ Birthdate ____________

Social Security # ______________ Relationship to Patient ______________

Address and Phone (if not listed above) ______________________________

Employer Address ______________________________________

Insurance Company Group # ______________ ID # ______________

Secondary Policy Holder's Full Name ______________________________ Birthdate ____________

Social Security # ______________ Relationship to Patient ______________

Address and Phone (if not listed above) ______________________________

Employer Address ______________________________________

Insurance Company Group # ______________ ID # ______________

DENTAL INFORMATION

Patient's General Dentist ______________________________ Last Appointment ____________

What are the main concerns you would like orthodontics to address? ______________

Has your child visited another orthodontist before? Yes No If YES, for what reason? ____________

Now or in the past, has the patient had:

Yes No Erupting teeth very early or very late?

Yes No Primary (baby) teeth removed that were not loose?

Yes No Supernumerary (extra) or congenitally missing teeth?

Yes No Popping, clicking, locking in jaw joints?

Yes No Soreness in jaw or face muscles?

Yes No Bleeding gums or gum disease?

Yes No Any sensitive or sore teeth?

Yes No Injury to teeth or jaws?

Yes No Frequent canker sores or cold sores?

Yes No Thumbsucking? (Stopped? Yes No)

Yes No Teeth causing irritation to lip, cheek or gums?

Yes No Tooth grinding or clenching?

MEDICAL HISTORY

Physician's Name ____________________________ Phone Number ______________________________

Does patient regularly receive medication or medical treatment? Yes No

If YES, why? ____

Does the patient take any medication(s), including non-prescription medicine? Yes No

If YES, please list ____

Is the patient allergic to any medications and/or latex? Yes No

If YES, please list ____

Is there a history of any serious illness, accident, or operation? Yes No

If YES, please elaborate ____

Now or in the past, has your child had:

Yes No Birth defects or hereditary problems?
Yes No Bone fractures, or major injuries?
Yes No Arthritis or joint problems?
Yes No Cancer, tumor, radiation treatment or chemotherapy?
Yes No Endocrine or thyroid problems?
Yes No Diabetes or low sugar?
Yes No Kidney problems?
Yes No Immune system problems?
Yes No Gonorrhea, syphilis, herpes, sexually transmitted diseases?
Yes No AIDS or HIV positive?
Yes No Hepatitis, jaundice or other liver problems?
Yes No Polio, mononucleosis, tuberculosis, pneumonia?
Yes No Seizures, fainting spells, neurologic problem?
Yes No Mental health disturbance or depression?
Yes No History of eating disorder?
Yes No Frequent headaches or migraines?
Yes No High or low blood pressure?
Yes No Excessive bleeding tendency or anemia?
Yes No Chest pain, shortness of breath, tire easily?
Yes No Heart defects, heart murmur, rheumatic heart disease?
Yes No Angina, arteriosclerosis, stroke, heart attack?
Yes No Vision, hearing, or speech problems?
Yes No Asthma, sinus problems, hayfever?
Yes No Tonsil or adenoid condition?
Yes No Does your child frequently breathe through his/her mouth?
Yes No Has your child ever taken intravenous or oral bisphosphonates for bone disorders/cancer?
Yes No Has your child ever been told to premedicate with antibiotics prior to dental treatment?

GROWTH INFORMATION

Weight _____ Height _____ Is Patient Still Growing? Yes No Amount last year _____ lbs _____ inches

Have you noticed a change or "growth spurt" recently? Yes No

If patient is a female, has menstration started? Yes No When ______________________

If patient is a male, has voice begun to change? Yes No When ______________________

AUTHORIZATION AND RELEASE

I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify Dr. Dobbs of any future change in the patient's health or medication. I also hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Dobbs to make a thorough diagnosis. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. Should I authorize direct payment of dental benefits otherwise payable to me to be payable to Dr. Dobbs directly, I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I understand, that where appropriate, a check of my credit history may be made. I also understand that my diagnostic records may be used for educational and promotional purposes.

______________________________ ______________________ __________

Parent/Responsible Party's Signature Relationship to Patient Date