Andrew Cedarbaum Orthodontics

PATIENT INFORMATION FORM FOR MINORS

Patient's Name: ______________________________ Preferred Name: ______________ Male ❑ Female ❑

Address: ______________________________ City: ______________________ Zip: __________

Home Phone: ______________________ Birth Date: ______________________ Age: __________

School: ____ Grade: ______________

Patient's Dentist: ______________________________ Did they refer you to our office? Yes ❑ No ❑

Is there someone other than your dentist whom we may thank for referring you to us? ______________________

Do you know any patients in our practice? ______________________________________

Who noticed an orthodontic problem? Patient ❑ Parent ❑ Dentist ❑ Other ❑: ______________________

Please describe the problem in your own words: ______________________________________

Patient's interests or hobbies: ______________________________________

Siblings' names and ages: ______________________________________

RESPONSIBLE PARTY INFORMATION

Name: ______________________________________ Relationship to patient: ______________

Address: ______________________________ City: ______________________ Zip: __________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ E-mail Address: ______________________

Occupation: ______________________ Social Security #: ______________ Birth Date: ______________

Employer name and address: ______________________________________

If additional responsible party:

Name: ______________________________________ Relationship to patient: ______________

Address: ______________________________ City: ______________________ Zip: __________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ E-mail Address: ______________________

Occupation: ______________________ Social Security #: ______________ Birth Date: ______________

Employer name and address: ______________________________________

Parents' Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single ❑ Remarried

If you have orthodontic insurance, name of insured: ______________________ ID#: ______________

Insurance Co.: ______________________________________ Group #: ______________

Insurance Co. address: ______________________________________ Phone #: ______________

If you have dual insurance, name of 2nd insured: ______________________ ID#: ______________

Insurance Co.: ______________________________________ Group #: ______________

Insurance Co. address: ______________________________________ Phone #: ______________

MEDICAL HISTORY

Physician's Name: ___________________________ Address ___________________________________ Phone: _________________

Has your child experienced any health problems?	❑Yes	❑No	Explain: ______________________________
Any major changes in your child's health recently?	❑Yes	❑No	Explain: ______________________________
Is your child currently under a physician's care?	❑Yes	❑No	Explain: ______________________________
Is your child currently taking any medications?	❑Yes	❑No	List: ______________________________
Is your child allergic to any medications?	❑Yes	❑No	List: ______________________________
Have tonsils or adenoids been removed?	❑Yes	❑No	When: ______________________________

Please check if your child has had any of the following conditions:

- ❑ Heart murmur
- ❑ Heart surgery
- ❑ Rheumatic fever
- ❑ Endocrine disorder
- ❑ Prolonged bleeding
- ❑ Anemia
- ❑ Blood disease
- ❑ Developmental/ growth disorder
- ❑ Hepatitis/ liver disease
- ❑ Diabetes
- ❑ Kidney disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Bronchitis
- ❑ Asthma
- ❑ Epilepsy
- ❑ Emotional problems
- ❑ Frequent headaches
- ❑ Nervous/anxious
- ❑ Cancer
- ❑ Bone disorders
- ❑ Hives/ rash
- ❑ Fainting
- ❑ Herpes (fever blisters)

Please use this space to further explain any above answers, or if there is any additional problem or condition we should know about:
____
____

GROWTH INFORMATION

Because growth and development play an important part in orthodontic diagnosis, your answers to the following questions are needed to aid in providing an optimal treatment plan.

Has your son or daughter reached puberty?	❑ Yes	❑ No	
Girls- has she started menstruating?	❑ Yes	❑ No	When? ______________________
Boys- has his voice changed?	❑ Yes	❑ No	When? ______________________
Is the patient adopted?	❑ Yes	❑ No	
Patient's height: ______________________			
Father's height: ______________________			
Mother's height: ______________________			
Do you feel that growth is complete?	❑ Yes	❑ No	
Have siblings or parents had orthodontics?	❑ Yes	❑ No	Pertinent history: ______________________

DENTAL HISTORY

Dentist's Name: _________________________ Address: ___________________________________ Phone: ___________________

Frequency of dental checkups: ____ Date of last visit: ____________________________

Is there any unfinished care to be completed?	❑Yes	❑No	Explain: ______________________________
Is your child frightened about dental treatment?	❑Yes	❑No	Explain: ______________________________
Had a bad experience in a dental office?	❑Yes	❑No	Explain: ______________________________
Has your child had any face or dental injuries?	❑Yes	❑No	Explain: ______________________________
Is there a history of finger or thumb sucking?	❑Yes	❑No	Stopped? ______________________________
Has your child consulted an orthodontist previously?	❑Yes	❑No	Who? ______________________________
Have primary or permanent teeth been removed?	❑Yes	❑No	Why? ______________________________
Has there been previous orthodontic treatment?	❑Yes	❑No	With whom? ______________________________

Please check if there is a history of:

- ❑ Clenching teeth
- ❑ Grinding teeth
- ❑ Speech problems
- ❑ Muscle soreness (head/neck)
- ❑ Tension headaches
- ❑ Mouth breathing
- ❑ Jaw joint soreness
- ❑ Tooth sensitivity
- ❑ Poor oral hygiene
- ❑ Jaw joint popping/clicking
- ❑ Bleeding gums
- ❑ Multiple cavities

Please list any other information that may be helpful: ____
____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I understand that credit bureau reports may be obtained. I authorize Dr. Cedarbaum to perform a complete orthodontic evaluation.

Parent's signature: ____Date: ___________________________