

# 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 2<sup>nd</sup> 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:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart murmur                   | <input type="checkbox"/> Hepatitis/ liver disease | <input type="checkbox"/> Emotional problems      |
| <input type="checkbox"/> Heart surgery                  | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Frequent headaches      |
| <input type="checkbox"/> Rheumatic fever                | <input type="checkbox"/> Kidney disease           | <input type="checkbox"/> Nervous/anxious         |
| <input type="checkbox"/> Endocrine disorder             | <input type="checkbox"/> Tonsillitis              | <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> Prolonged bleeding             | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Bone disorders          |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> Hives/ rash             |
| <input type="checkbox"/> Blood disease                  | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Fainting                |
| <input type="checkbox"/> Developmental/ growth disorder | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> 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:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Muscle soreness (head/neck) | <input type="checkbox"/> Jaw joint soreness | <input type="checkbox"/> Jaw joint popping/clicking |
| <input type="checkbox"/> Grinding teeth  | <input type="checkbox"/> Tension headaches           | <input type="checkbox"/> Tooth sensitivity  | <input type="checkbox"/> Bleeding gums              |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Mouth breathing             | <input type="checkbox"/> Poor oral hygiene  | <input type="checkbox"/> 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: \_\_\_\_\_