GLANDER | ROCHFORD
ORTHODONTICS

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Patient's Family Information, Medical, & Dental History (Child/Young Adult)

(please complete in ink)

Today's Date ______________________

Patient's Name ____ Nickname ____________ Age____ Sex____ Date of Birth ____________
First Last M.I.

Address ____ ________________ __________ Tel. # (____) ______________
Street City Zip

School ____ Grade ________

Best telephone number to call for appointments (During Business Hours) ______________________________

Guardian's Cell# ______________ Guardian's Cell# ______________ Best E-mail Address ______________________

Parent/ Guardian #1 ____ SS # ______________________
First Last M.I. (for Insurance purposes only)

Date of Birth ______________________ Insurance ID # ______________________

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Remarried ❑ Other

Home Address ____ Home Tel. # (____) ______________
Street City Zip

Employed by ______________________ Occupation ______________ Position ______________

Employer Address ____ Work Tel. # (____) ______________
Street City Zip

Does guardian have Orthodontic Insurance? _____Yes _____ No Name of Insurance Company ______________________
(This may be different from Dental Insurance)

Parent/ Guardian #2 ____ SS #______________________
First Last w. (for Insurance purposes only)

Date of Birth ______________________ Insurance ID # ______________________

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Remarried ❑ Other

Home Address ____ Home Tel. # (____) ______________
Street City Zip

Employed by ______________________ Occupation ______________ Position ______________

Employer Address ____ Work Tel. # (____) ______________
Street City Zip

Does guardian have Orthodontic Insurance? _____Yes _____ No Name of Insurance Company ______________________
(This may be different from Dental Insurance)

Patient's Family Dentist ____
Name Address Tel. #

Whom may we thank for referring you to our office? ______________________________________

If responsible party is other than the patient's parents, please give information: (grandparent or step parent) Not Applicable ❑

Name ______ S.S. # ______ Relationship to patient ______
(for Insurance purposes only)

Insurance ID # ______ Date of Birth ______

Address ______ Tel. # ( ) ______
Street City Zip

Employed by ______

Employer Address ______ Work Tel. # ( ) ______
Street City Zip

Does Responsible Party have Orthodontic Insurance? ____Yes ____No Name of Insurance Company ______
(This may be different from Dental Insurance)

Does Responsible Party have Medical Insurance? ____Yes ____No Name of Insurance Company ______

MEDICAL HISTORY

Patient's Family Physician ______
Name Address Tel. #

Has patient had or does patient have any of the following?

	Yes	No		Yes	No
Rheumatic Fever	❑	❑	Persistent Headaches	❑	❑
Heart Murmur	❑	❑	Neck Pains	❑	❑
High Blood Pressure	❑	❑	Nerve or Brain Disease	❑	❑
Heart Attack/Stroke	❑	❑	Migraine or Headaches	❑	❑
Blood Vessel Disease	❑	❑	Epilepsy	❑	❑
Blood Disorder	❑	❑	Mental Health Problems	❑	❑
AIDS/HIV Infection	❑	❑	Bone Disorders	❑	❑
Hepatitis (Any type)	❑	❑	Arthritis (Any type)	❑	❑
Diabetes	❑	❑	Sleep Apnea	❑	❑
Ulcers	❑	❑	Ear Disorder	❑	❑
Herpes (Any type)	❑	❑	Sinus Infection	❑	❑
Psoriasis	❑	❑	Swollen Glands	❑	❑
Cancer	❑	❑	Allergies	❑	❑

Comments ______

Please list any other significant information about the patient's medical history: ______

Yes	No	
❑	❑	Is patient under a physician's care at present? If yes, reason? ______
❑	❑	Is patient presently, or has patient ever been, under the care of a psychiatrist or psychologist? If yes, describe ______
❑	❑	Is patient currently taking any medication? If yes, describe ______
❑	❑	Is patient allergic to any medications? (Eg: aspirin, penicillin, etc.) If yes, list. ______
❑	❑	Has patient ever had any general anesthesia? When & why? ______
❑	❑	Does patient take any vitamins? If yes, what type? ______

DENTAL HISTORY

Yes	No	
❑	❑	Do any teeth hurt? If yes, ❑ upper right ❑ upper left ❑ lower right ❑ lower left
❑	❑	Have any wisdom teeth been removed? How many? ________
❑	❑	Has he/she ever had treatment for a periodontal disease (gum disease)? If yes, describe ________
❑	❑	Has he/she ever had any previous orthodontic treatment (braces)? If yes, when ________
		If yes, doctor's name and address ________
❑	❑	Have there been any injuries to his/her mouth or teeth? If yes, describe ________
❑	❑	Has he/she ever had any injury to the head or neck area? If yes, describe ________
❑	❑	Has he/she ever fallen and bumped his/her chin, or received any trauma to his/her jaws? If yes, describe ________
❑	❑	When was the patient's last dental visit? ________
❑	❑	Does he/she clench or grind his/her teeth? If yes, ❑ while sleeping ❑ under stress ❑ other ________
❑	❑	Do his/her jaw muscles ever feel tired? If yes, when ________
❑	❑	Has he/she ever noticed soreness, tightness or pain in the muscles around the jaws or face? If yes, describe ________
❑	❑	Does it hurt to chew? If yes, where does it hurt? ________
❑	❑	Does he/she ever hear clicking (popping) or grating sounds in his/her jaw joints? If yes, please describe:

	Right	Left	Since when	During what activity
❑ Clicking:	❑	❑	________	________
❑ Grating:	❑	❑	________	________

Did these joint sounds begin gradually or suddenly? ❑ gradually ❑ suddenly

Yes	No	
❑	❑	Was there some specific event that started the joint sound or pain? If yes, describe ________
❑	❑	Has he/she ever experienced difficulty in opening or closing his/her jaws? If yes, describe ________
❑	❑	Have his/her jaws ever "locked" closed? If yes, describe ________
❑	❑	Have his/her jaws ever "locked" wide open? If yes, describe ________
❑	❑	Does he/she have pain in his/her jaw joints? If yes, ❑ right ❑ left Since when? ________
❑	❑	Did his/her pain start gradually or suddenly? ❑ gradually ❑ suddenly
		During what activity? ________ Describe nature of pain ________
		What increases the pain? ________ What decreases the pain? ________

Does the patient have any of the following habits?

Yes	No	
❑	❑	Finger/Thumb sucking
❑	❑	Lip Biting
❑	❑	Nail Biting
❑	❑	Gum Chewing
❑	❑	Ice Chewing

Yes	No	
❑	❑	Do you drink soda, coffee, tea? (caffeinated beverages)
❑	❑	Smoke or Smokeless Tobacco User?

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GROWTH AND DEVELOPMENT

Yes	No	
❑	❑	Has patient reached adolescent growth? ______
❑	❑	Girls - Has monthly cycle started yet? If so, when ______
❑	❑	Boys - Has voice changed yet? If so, when ______
❑	❑	Is the patient adopted? Does the patient know? Yes ❑ No ❑
❑	❑	Are there any learning disabilities? If yes, explain ______
❑	❑	Are there other children in the family?
		Names and ages ______
❑	❑	Has any other member of the family had orthodontic treatment? ______
❑	❑	Has any other member of the family been a patient in this office?
		Name(s) ______

Please describe why you sought this consultation

❑	❑	Has patient ever been treated for this problem before? If yes, please describe the diagnosis and treatment ______

Any information you can give us concerning your child will be appreciated. The more we know about each patient, the more help we can give in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies:

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

(Signature of Responsible Adult) ______ Date ______

Doctor's Notes ______

(Doctor's Signature) ______ Date ______