Sullivan ORTHODONTICS

Teen Patient Information

Patient Information

Date	
Patient's Name	
Preferred Name/Nickname	
Address	
Birth Date	**Age**
Sex ❑ Male ❑ Female	
Primary Phone	
Cell Phone	
Work Phone	
Have we treated any other family members? ❑ Yes ❑ No	
Names of family members treated	
If patient is a minor, give parent's or guardian's name	

Responsible Party Information

Name	
Address	
How long at this address	
Previous Address (if less than 3 yrs)	
E-Mail Address	
Primary Phone	**Cell Phone**
Work Phone	**Birth Date**
Relationship to Patient	
Employer	
Occupation	
No. Years Employed	
Marital status: ❑ single ❑ married ❑ partner ❑ divorced ❑ widowed	
Spouse/Partner	
Cell Phone	**Work Phone**
Birth Date	
Relationship to Patient	
Employer	
Occupation	
No. Years Employed	

Orthodontic Insurance Information

Insured's Name	
Birth Date	**SSN**
Insurance Company	

Orthodontic Insurance Information

Group No.	
Local No.	
Insurance Co Address	
Phone	
Do you have dual coverage? ❑ Yes ❑ No	
2nd Insured's Name	
Birth Date	**SSN**
Insurance Company	
Group No.	
Local No.	
Insurance Co Address	
Phone	

Emergency Information

Emergency Contact Person (not living with you)
Complete Address
Phone

Sullivan ORTHODONTICS

Teen Medical Information

Medical History

Patient's Name			
For the questions check yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.			
Patient Profile			
	yes	**no**	**dk/u**
Does patient follow directions well?	❑	❑	❑
Does patient brush his/her teeth conscientiously?	❑	❑	❑
Does patient have learning disabilities or need extra help with instructions?	❑	❑	❑
Is patient sensitive or self-conscious about teeth?	❑	❑	❑

Now or in the past has the patient had any of the following: (If yes please explain)

	yes	**no**	**dk/u**	
Birth defects or hereditary problems?	❑	❑	❑	
Bone fractures, any major accidents?	❑	❑	❑	
Rheumatoid or arthritic conditions?	❑	❑	❑	
Endocrine or thyroid problems?	❑	❑	❑	
Kidney problems?	❑	❑	❑	
Diabetes?	❑	❑	❑	
Cancer, tumor, radiation treatment or chemotherapy?	❑	❑	❑	
Stomach ulcer or hyperacidity?	❑	❑	❑	
Polio, mononucleosis, tuberculosis or pneumonia?	❑	❑	❑	
Problems of the immune system?	❑	❑	❑	
AIDS or HIV positive?	❑	❑	❑	
Hepatitis, jaundice or liver problem?	❑	❑	❑	
Fainting spells, seizures, epilepsy or neurological problem?	❑	❑	❑	
Mental health disturbance or behavioral problem?	❑	❑	❑	
Vision, hearing, tasting or speech difficulties?	❑	❑	❑	
Loss of weight recently, poor appetite?	❑	❑	❑	

Medical History

	yes	no	dk/u	
History of eating disorder (anorexia/bulimia)?	❑	❑	❑	
Excessive bleeding or bruising tendency, anemia or bleeding disorder?	❑	❑	❑	
High or low blood pressure?	❑	❑	❑	
Tires easily?	❑	❑	❑	
Chest pain, shortness of breath or swelling ankles?	❑	❑	❑	
Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease?	❑	❑	❑	
Skin disorder?	❑	❑	❑	
Frequent headaches, colds or sore throats?	❑	❑	❑	
Eye, ear, nose or throat condition?	❑	❑	❑	
Hayfever, asthma, sinus trouble or hives?	❑	❑	❑	
Tonsil or adenoid conditions?	❑	❑	❑	
Sleep Apnea?	❑	❑	❑	

Allergies or reactions to any of the following:

	yes	no	dk/u	
Local anesthetics (Novocaine or Lidocaine)	❑	❑	❑	
Aspirin	❑	❑	❑	
Ibuprofen (Motrin, Advil)	❑	❑	❑	
Penicillin or other antibiotics	❑	❑	❑	
Sulfa drugs	❑	❑	❑	
Codeine or other narcotics	❑	❑	❑	
Metal (jewelry, clothing snaps)	❑	❑	❑	
Latex (gloves, balloons)	❑	❑	❑	
Vinyl	❑	❑	❑	
Acrylic	❑	❑	❑	
Animals	❑	❑	❑	
Foods (specify)	❑	❑	❑	
Other substances (specify)	❑	❑	❑	

Medical History

Medications				
	yes	**no**	**dk/u**	
Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine?	❑	❑	❑	

Please list all medications	
Medication	**Taken for**
Medication	**Taken for**
Medication	**Taken for**

	yes	**no**	**dk/u**	
Does the patient currently have or ever had a substance abuse problem?	❑	❑	❑	
Does the patient chew or smoke tobacco?	❑	❑	❑	
Operations? Describe:	❑	❑	❑	
Hospitalized? For:	❑	❑	❑	
Other physical problems or symptoms? Describe:	❑	❑	❑	
Being treated by another health care professional? For:	❑	❑	❑	
Date of most recent physical exam?	❑	❑	❑	

Are there any other medicial conditions that we should be aware of:

Family Medical History

Girls Only				
	yes	**no**	**dk/u**	
Has the patient started her monthly periods? If so, approximately when?	❑	❑	❑	
Is the patient currently pregnant?	❑	❑	❑	
Is the patient planning on becoming pregnant in the next 12 months?	❑	❑	❑	
Are you breastfeeding?	❑	❑	❑	

Family Medical History

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

	yes	no	dk/u	
Bleeding disorders	❑	❑	❑	
Diabetes	❑	❑	❑	
Arthritis	❑	❑	❑	
Metabolic disturbances	❑	❑	❑	
Severe allergies	❑	❑	❑	
Unusual dental problems	❑	❑	❑	
Jaw size imbalance	❑	❑	❑	
Any other family medical conditions that we should know about?	❑	❑	❑	

Name of Physician	**Phone Number**
Location	**Last Visit**

Sullivan ORTHODONTICS

Dental Information

Dental History

Patient's Name			
Dentist's Name		**Specialist or Other**	
What is your primary concern?			
For the questions check yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.			
Now or in the past, has the patient had:			
	yes	**no**	**dk/u**
Permanent or "extra" (supernumerary) teeth removed?	❑	❑	❑
Supernumerary (extra) or congenitally missing teeth?	❑	❑	❑
Chipped or otherwise injured primary (baby) or permanent teeth?	❑	❑	❑
Teeth sensitive to hot or cold, teeth throb or ache?	❑	❑	❑
Jaw fractures, cysts or mouth infections?	❑	❑	❑
"Dead teeth" or root canals treated?	❑	❑	❑
Bleeding gums, bad taste or mouth odor?	❑	❑	❑
Periodontal "gum problems"?	❑	❑	❑
Food impaction between teeth?	❑	❑	❑
"Gum boils", frequent canker sores or cold sores?	❑	❑	❑
Abnormal swallowing habit (tongue thrusting)?	❑	❑	❑
History of speech problems?	❑	❑	❑
Mouth breathing habit, snoring or difficulty in breathing?	❑	❑	❑
Tooth grinding, jaw clenching clicking or locking?	❑	❑	❑
Any pain in jaw or ringing in the ears?	❑	❑	❑
Any pain or soreness in the muscles of the face or around the ears?	❑	❑	❑
Difficulty in chewing or jaw opening?	❑	❑	❑
Have you even been treated for "TMD" or "TMJ" problems?	❑	❑	❑
Thumb, finger, or sucking habit? Until what age?	❑	❑	❑
.			

Dental History

	yes	no	dk/u
Aware of loose, broken or missing restorations (fillings)?	❑	❑	❑
Any teeth irriating cheek, lip, tongue or palate?	❑	❑	❑
Concerned about spaced, crooked or protruding teeth?	❑	❑	❑
Aware or concerned about under or over developed jaw?	❑	❑	❑
Any relative with similar tooth or jaw relationships?	❑	❑	❑
Any wisdom tooth problems?	❑	❑	❑
Had periodontal (gum) treatment?	❑	❑	❑
Had any serious trouble associated with any previous dental treatment?	❑	❑	❑
Would you object to wearing orthodontic appliances (braces) should they be indicated?	❑	❑	❑
Ever had a prior orthodontic examination or treatment?	❑	❑	❑
Current dentist's care?	❑	❑	❑
How often do you brush?		**Floss?**	

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Patient Signature:

Date: