



## CHILD ORTHODONTIC PATIENT QUESTIONNAIRE

Patient's name: \_\_\_\_\_ Preferred name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F E-mail address: \_\_\_\_\_

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Telephone: (\_\_\_\_) \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade level: \_\_\_\_\_

Hobbies/Interests: \_\_\_\_\_

**Name of responsible party:** \_\_\_\_\_ Preferred name: \_\_\_\_\_

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Home Telephone: (\_\_\_\_) \_\_\_\_\_

Work Telephone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Why are you and your child seeking orthodontic treatment? (Please be as specific as possible):

\_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

### **FAMILY STATUS**

Father's name: \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone(\_\_\_\_) \_\_\_\_\_

Mother's name: \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone(\_\_\_\_) \_\_\_\_\_

Marital Status of parents: \_\_\_\_\_ Is the patient adopted? Yes No

### **INSURANCE INFORMATION** Will you be using dental insurance? Yes No

Insurance company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Employer: \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

### **DENTAL HISTORY**

General Dentist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Date of last dental examination: \_\_\_\_\_

Has another member of the family had orthodontic treatment Yes No Who? \_\_\_\_\_

Has this patient had a previous orthodontic consultation? Yes No

**MEDICAL HISTORY**

Family Physician: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Is the patient currently under a physician's care? Yes No

If yes, please explain \_\_\_\_\_

Is the patient taking any medicine at this time? Yes No

If yes, please list \_\_\_\_\_

Is the patient allergic to any medications? Yes No If yes, please list \_\_\_\_\_

Does the patient have any other allergies? Yes No If yes, please list \_\_\_\_\_

Does the patient need to be premedicated (with antibiotics) for routine dental procedures? Yes No

If yes, please specify and give reason for this need: \_\_\_\_\_

Has the patient ever been hospitalized? Yes No If yes, please explain \_\_\_\_\_

Females: Is the patient pregnant? Yes No

**Does the patient have or has the patient ever had any of the following?**

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Injury to head
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Oral Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Radiation or cancer therapy
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils/Adenoid Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Injury to face/teeth/gums

Does the patient have any disease, condition, or problem not listed above? Please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DOES/DID THE PATIENT:**

Grind his/her teeth at night? Yes No Brush his/her teeth  Often  Occasionally  Reluctantly

Suck thumb, finger, pacifier? Yes No If yes, what age was the habit discontinued? \_\_\_\_\_

**PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT**

Is the patient aware of the problem? Yes No

The patient's interest in having treatment is:  Excited  Willing if necessary  Reluctant

**BEHAVIOR ASSESMENT**

Personality (check any that apply):

Calm  Nervous  Quiet  Shy  Outgoing  Uncooperative  Cooperative  Confident

Afraid  Emotional disturbance

Progress at school when compared to children of the same age:

Behind  Same Level  Advanced

**GROWTH STATUS:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Females: Has the patient started her menstruation? Yes No If yes, what age? \_\_\_\_\_

Males: Has the patient yet undergone voice changes? Yes No Facial hair growth? Yes No

**Thanks for your help. We're excited to get to know you better!**

Signature of the person completing this form: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ Today's Date: \_\_\_\_\_