



**Pediatric Dentistry**  
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**Orthodontics**  
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**Pediatric Dentistry of Central Florida**  
BISHOP • BERTOT

Date: \_\_\_\_\_

**Orthodontic Patient Information**

Patient's Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Nickname \_\_\_\_\_  
Address \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Fax \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
E-Mail Address \_\_\_\_\_  
School/Employer \_\_\_\_\_ Grade \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_  
Siblings/Children Yes/No Name/Age \_\_\_\_\_ Name/Age \_\_\_\_\_ Name/Age \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Residence \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ How long at this address? \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Own \_\_\_\_\_ Rent \_\_\_\_\_ Home Phone \_\_\_\_\_ Fax \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Previous Address (if less than 3 years) \_\_\_\_\_  
Birthdate \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Marital Status \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_  
No. Years Employed \_\_\_\_\_ Occupation \_\_\_\_\_ Phone: Work \_\_\_\_\_ Cell \_\_\_\_\_

**Orthodontic Insurance Information**

Primary Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_  
Primary Insured's Address \_\_\_\_\_  
Insured's Employer \_\_\_\_\_  
Insured's Employer Address \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Do you have dual coverage? Yes  No  If yes:  
Secondary Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_  
Insured's Address \_\_\_\_\_  
Insured's Employer \_\_\_\_\_  
Insured's Employer Address \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_

## Medical History

Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Please circle Yes or No (if Yes, please fill in details).

YES NO Are you taking any medication? \_\_\_\_\_

YES NO Are you allergic to any medication? \_\_\_\_\_

YES NO Do you have a history of major illness? \_\_\_\_\_

YES NO Have you had any major operations? \_\_\_\_\_

YES NO Have you ever been involved in a serious accident? \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have.

AIDS	Diabetes	Hepatitis	Nervous Disorders	Tumor or Cancer
Anemia	Dizziness	Herpes	Pneumonia	
Arthritis	Epilepsy	High Blood Pressure	Prolonged Bleeding	
Asthma or Hay Fever	Gastrointestinal Disorders	Kidney Involvement	Rheumatic Fever	
Bone Disorders	Heart Problems	Liver Involvement	Tuberculosis	

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

If child, have you reached puberty? Girls-have you started menstruation? \_\_\_\_\_ Boys-has your voice changed? \_\_\_\_\_

## Dentist

Dentist \_\_\_\_\_ Date of last cleaning \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

## Orthodontic Concerns

PLEASE describe what concerns you most about your teeth \_\_\_\_\_

## Dental History

YES NO Are you presently in any dental *pain*? \_\_\_\_\_

YES NO Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_

YES NO Have you ever lost or chipped any teeth? \_\_\_\_\_

YES NO Have there ever been any injuries to face, mouth, or teeth? \_\_\_\_\_

YES NO Is any part of your mouth sensitive to temperature or pressure? \_\_\_\_\_

YES NO Do your gums bleed when you brush? \_\_\_\_\_

YES NO Do you have any type of thumb or tongue habit? \_\_\_\_\_

YES NO Are you a mouth breather? \_\_\_\_\_

YES NO Have you ever seen an orthodontist? \_\_\_\_\_

YES NO Has anyone in the family received orthodontic treatment? \_\_\_\_\_

YES NO How did they feel about the result? \_\_\_\_\_

YES NO What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_

YES NO Do you have any pain or soreness around your face, neck or back? \_\_\_\_\_

YES NO Are your teeth or jaws ever uncomfortable when you awaken in the morning? \_\_\_\_\_

YES NO Are you aware of your jaw clicking or popping? \_\_\_\_\_

YES NO Are you aware of clenching your teeth during the day? \_\_\_\_\_

YES NO Have you ever been told that you grind your teeth? \_\_\_\_\_

YES NO Do you have "tension" headaches? \_\_\_\_\_

YES NO Have you ever experienced ringing in your ears? \_\_\_\_\_

YES NO Are you aware that some appointments will be during school/work hours? \_\_\_\_\_

## Benefits of Orthodontics

### AESTHETICS, HEALTH AND FUNCTION

Orthodontics is a service that provides an improvement in the appearance of the teeth, and in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases.

I hereby state that I have read and understand the above paragraph and that I have truthfully, to the best of my ability, answered all the above questions.

\_\_\_\_\_  
Patient/Parent

\_\_\_\_\_  
Date