*Diplomate American Board of Pediatric Dentistry

Pediatric Dentistry
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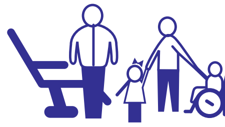

Pediatric Dentistry of Central Florida

BISHOP • BERTOT

Orthodontics
John R. Smith, D.D.S., M.S.D.

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 ______________ Last ______________ First ______________ Middle Social Security # ______________
Residence ______________ 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 ______________ Last ______________ First ______________ Middle Birthdate ______________
Spouse's Employer ______________ 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