GOTTSEGEN ORTHODONTICS

NEW PATIENT INFORMATION FORM (CHILD)

PLEASE FILL OUT <u>BOTH SIDES</u> OF THIS SHEET. THANK YOU.

<u>PATIENT INFORMATION</u> DATE: _____

NAME: (last) _____ (first) _____ (middle) _____

NICKNAME: _____ BIRTHDATE: _____/_____/_____ AGE: _____

GENERAL DENTIST: _____ PHYSICIAN: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?: _____

WHAT IS YOUR CHIEF CONCERN THAT BRINGS YOU TO OUR OFFICE?: _____

_____

<u>CONTACT INFORMATION</u>

RESPONSIBLE PARTY #1 RELATIONSHIP TO PATIENT _____

FIRST NAME: _____ LAST NAME: _____

ADDRESS: (street)_____ (city)_____ (state)_____ (zip)_____

HOME#: _____ WORK #: _____ CELL #: _____

EMAIL ADDRESS: _____ CELLULAR PROVIDER _____

EMPLOYER: _____ OCCUPATION: _____

RESPONSIBLE PARTY #2 RELATIONSHIP TO PATIENT _____

FIRST NAME: _____ LAST NAME: _____

ADDRESS: (street)_____ (city)_____ (state)_____ (zip)_____

HOME#: _____ WORK#: _____ CELL#: _____

EMAIL ADDRESS: _____ CELLULAR PROVIDER _____

EMPLOYER: _____ OCCUPATION: _____

<u>DENTAL INSURANCE INFORMATION</u>

PLEASE PROVIDE YOUR INSURANCE CARD TO OUR RECEPTIONIST SO THAT WE MAY MAKE A COPY OF IT FOR OUR RECORDS.

PATIENT'S SOC. SEC. #: _____

RESPONSIBLE PARTY #1 SSN: _____ DATE OF BIRTH: _____

RESPONSIBLE PARTY #2 SSN: _____ DATE OF BIRTH: _____

OVER →

MEDICAL AND DENTAL HISTORY

PLEASE DESCRIBE ANY IMPORTANT MEDICAL HISTORY OF WHICH WE SHOULD BE AWARE?:

_____

IS THE PATIENT CURRENTLY UNDER THE CARE OF A PHYSICIAN? IF YES, DESCRIBE: _____

_____

IS THE PATIENT CURRENTLY TAKING ANY MEDICATIONS, INCLUDING PRESCRIPTION AND/OR OVER-THE-COUNTER? _____

DOES THE PATIENT HAVE A HISTORY OF HEART MURMUR, PROSTHETIC HEART VALVES, RHEUMATIC FEVER, OR ANY OTHER CONDITION THAT MAY REQUIRE PREMEDICATION WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT? IF YES, PLEASE DESCRIBE: _____

_____

IS THE PATIENT ALLERGIC TO ANY MEDICATIONS?: WHICH? : _____

IS THE PATIENT ALLERGIC TO LATEX?: YES NO

HAVE THE PATIENT'S TONSILS BEEN REMOVED?: YES NO ADENOIDS?: YES NO

IS THE PATIENT EXPERIENCING ANY PAIN, POPPING OR CLICKING SOUNDS, FACIAL PAIN, OR ANY OTHER DYSFUNCTION IN THE AREA OF THE JAW JOINTS (TMJ)? YES NO

IF YES, PLEASE REQUEST A TMJ QUESTIONNAIRE FROM THE RECEPTIONIST TO ASSIST US WITH OUR EXAMINATION AND DIAGNOSIS OF THE PATIENT.

HAS THE PATIENT BEEN INVOLVED IN ANY ACCIDENT WHICH HAS CAUSED INJURY TO THE TEETH OR JAWS? IF YES, DESCRIBE, AND GIVE THE DATE OF TRAUMA: _____

_____

PLEASE CIRCLE HISTORY OF ANY OF THE FOLLOWING IMPORTANT HABITS, IF PRESENT:

THUMB/FINGER SUCKING TONGUE THRUST NAIL BITING LIP/CHEEK BITING SMOKING

FOR YOUNG GIRLS ONLY: IN ORDER FOR US TO ASSESS THE GROWTH STATUS AND STAGE OF PHYSICAL MATURATION OF THE PATIENT, PLEASE INDICATE THE FOLLOWING:

HAS MENSTRUATION BEGUN?: YES NO IF YES, WHEN?: _____