WELCOME TO
MARTIN ORTHODONTICS

PATIENT INFORMATION FORM FOR MINORS

Patient's Name _____ Nickname _____ Sex _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Birthdate _____ Age _____ School _____ Grade _____

Email Address _____

Patient's Dentist _____ Did they refer you to this office? ☐ Yes ☐ No

Do you know a patient in our practice? ☐ Yes ☐ No If so, whom? _____

Is there someone other than your dentist we may thank for referring you to us? ☐ Yes ☐ No (very important to us)

If so, whom? _____

Who noticed an orthodontic problem ☐ Patient ☐ Dentist ☐ Other _____

Please describe your child's orthodontic problem in your own words _____

Patient's interests or hobbies _____

Siblings names and ages _____

PARENT / GUARDIAN INFORMATION

Relationship to Patient ☐ Mother ☐ Father ☐ Step Parent ☐ Other (specify) _____

Name _____ SS # _____

Street Address _____ DOB _____

City _____ State _____ Zip _____

Employed By _____ Occupation or Job Title _____

Work Phone (_____) _____ Home Phone (_____) _____

Cell Phone (_____) _____ Email Address _____

Relationship to Patient ☐ Mother ☐ Father ☐ Step Parent ☐ Other (specify) _____

Name _____ SS # _____

Street Address _____ DOB _____

City _____ State _____ Zip _____

Employed By _____ Occupation or Job Title _____

Work Phone (_____) _____ Home Phone (_____) _____

Cell Phone (_____) _____ Email Address _____

INSURANCE INFORMATION

Is patient covered by orthodontic insurance? ☐ Yes ☐ No

Name of Insured _____ SS # _____ DOB _____

Name of Insurance Company _____

Insurance Claims Address _____

Insurance Telephone Number _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature _____ Date _____

Please Fill Out Back

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: _____ Address _____ Phone_____

Has your child experienced any health problems? ☐ No ☐ Yes Explain: _____
Any major change in your child's health recently? ☐ No ☐ Yes Explain: _____
Is your child currently under physician's care? ☐ No ☐ Yes Explain: _____
Is your child currently taking medications? ☐ No ☐ Yes List: _____
Does your child require pre-medication for any dental procedure? ☐ No ☐ Yes List: _____
Is your child allergic to any medications? ☐ No ☐ Yes List: _____
Has your child received a blood transfusion? ☐ No ☐ Yes Reason: _____
Have your child's tonsils or adenoids been removed? ☐ No ☐ Yes When: _____
Has your child been in a risk group for AIDS? ☐ No ☐ Yes Explain: _____

Please check appropriate box:

Heart Murmur	☐ NO	☐ YES	Hepatitis	☐ NO	☐ YES	Emotional Problems	☐ NO	☐ YES
Heart Surgery	☐ NO	☐ YES	Diabetes	☐ NO	☐ YES	Frequent Headaches	☐ NO	☐ YES
Rheumatic Fever	☐ NO	☐ YES	Kidney Disease	☐ NO	☐ YES	Nervous/Anxious	☐ NO	☐ YES
Endocrine Disorders	☐ NO	☐ YES	Liver Disease	☐ NO	☐ YES	Cancer	☐ NO	☐ YES
Prolonged Bleeding	☐ NO	☐ YES	Tuberculosis	☐ NO	☐ YES	Bone Disorders	☐ NO	☐ YES
Anemia	☐ NO	☐ YES	Bronchitis	☐ NO	☐ YES	Growth Disorders	☐ NO	☐ YES
Blood Disease	☐ NO	☐ YES	Asthma	☐ NO	☐ YES	Mouth Breather	☐ NO	☐ YES
Developmental Disorder	☐ NO	☐ YES	Epilepsy	☐ NO	☐ YES	Herpes (Fever Blisters)	☐ NO	☐ YES
Hives/Rash	☐ NO	☐ YES	Fainting	☐ NO	☐ YES	Tonsillitis	☐ NO	☐ YES

Is there any other condition or problem that you think we should know about? _____

_____

Comments: _____

Growth Information for Patients Under 16 Years of Age
Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives:

Has your son or daughter reached puberty? ☐ No ☐ Yes
Girls - Has she started menstruation ☐ No ☐ Yes When? _____
Boys - Has his voice changed? ☐ No ☐ Yes When? _____
Height _____ Do you feel growth is completed? ☐ No ☐ Yes
Father's Height _____ Mother's Height _____ Adopted? ☐ No ☐ Yes
Names and Birthdates of patient's brothers and sisters: _____
Have either siblings or parents had orthodontic treatment? ☐ No ☐ Yes With whom: _____

DENTAL HISTORY

Dentist's Name: _____ Address _____ Phone_____

Frequency of dental checkups: Twice a year ☐ Once a year ☐ Only if a problem exists ☐ Never ☐ Date of last visit _____

Is there any unfinished care to be completed with your child's dentist ☐ No ☐ Yes Explain: _____
Is your child frightened about dental treatment? ☐ No ☐ Yes Explain: _____
Has your child had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain: _____
Has your child had any face or dental injuries? ☐ No ☐ Yes Explain: _____
Is there any history of thumb or finger sucking? ☐ No ☐ Yes Stopped? _____
Does your child play any musical instruments? ☐ No ☐ Yes What Instrument: _____
Has your child consulted an orthodontist previously? ☐ No ☐ Yes With whom? _____
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes _____
Has your child had any previous orthodontic treatment? ☐ No ☐ Yes With whom? _____
Are you satisfied with prior treatment? ☐ No ☐ Yes Explain: _____

Please check if there is a history of:

☐ Clenching teeth ☐ Muscular soreness around head & neck ☐ Jaw joint soreness ☐ Jaw joint popping
☐ Grinding teeth Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in the ears
☐ Speech problems (If so, which sounds_____) ☐ Mouthbreathing: Awake ☐ Asleep ☐

Is there any other information that may be helpful? _____

_____ _____ Reviewed by: _____
Parent's Signature Date