



Davies

ORTHODONTICS

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PATIENT INFORMATION – Child or Teen

Patient's Name (Full Name) _____ Age _____ DOB _____

Nickname (if preferred) _____ Male Female Is Patient Adopted? Yes No Home Phone _____

Patient's Home Address _____ City, State, Zip _____

Patient's General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? Yes No If yes, please name _____

Patient's School _____ Patient's Grade _____ Number of Siblings _____

Has the patient visited another orthodontist before? Yes No If yes, for what reason? _____

What are the main concerns that you would like orthodontics to accomplish? _____

What is the name of the person filling this form out? _____ Relationship to the patient? _____

FATHER'S INFORMATION - Father Step Father Guardian

Father's Marital Status Single Married Widowed Divorced Separated Domestic Partner

Father's Name (Full) _____ DOB _____ SS# _____

Father's Address (if different from patient's) _____ Email address _____

Father's Home Phone _____ Work Phone _____ Cell Phone _____

Father's Employer _____ Father's Occupation _____

Employer's Address _____ Employer's Phone _____

If you have DENTAL insurance coverage for your child, please fill out the information below.

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group # or ID _____

MOTHER'S INFORMATION - Mother Step Mother Guardian

Mother's Marital Status Single Married Widowed Divorced Separated Domestic Partner

Mother's Name (Full) _____ DOB _____ SS# _____

Mother's Address (if different from patient's) _____ Email address _____

Mother's Home Phone _____ Work Phone _____ Cell Phone _____

Mother's Employer _____ Mother's Occupation _____

Employer's Address _____ Employer's Phone _____

If you have DENTAL insurance coverage for your child, please fill out the information below.

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group # or ID _____

MEDICAL AND DENTAL HISTORY

Patient's Physician _____ Is the patient currently under the care of a physician other than general care? Yes No

If yes, for what reason? _____

Does the patient require medication/antibiotics before dental treatment? Yes No If yes, please explain _____

Any sensitivities or allergies to the following? (only answer if yes to any)

Latex Sulfa drugs Penicillin or other antibiotics

Nickel, silver, or any other metals Foods (please list) _____ Local anesthetics

Other (please list) _____

Currently taking medication (please include non-prescription medication)? Yes No If yes, please list _____

Please circle Y (yes) or N (no) for the following questions, whichever applies. Your answers are for our records only and will be considered confidential.

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| Y N Is the patient in excellent health? | Y N Has there been any change in the patient's general health within the last year? |
| Y N Respiratory problems, emphysema | Y N Asthma or hay fever |
| Y N Sinus trouble | Y N Persistent swollen neck glands |
| Y N Thyroid or endocrine problems | Y N Diabetes |
| Y N Hepatitis, jaundice or liver disease | Y N AIDS or HIV infection |
| Y N Sexually transmitted disease | Y N Substance abuse problem (past or present) |
| Y N Mental health problem or nervous disorder | Y N Fainting spells or seizures |
| Y N Epilepsy or other neurological disease | Y N Blood disorder such as anemia |
| Y N Abnormal bleeding or blood transfusion | Y N Low blood pressure |
| Y N Arthritis or joint problems or artificial joints/limbs | Y N Birth Defects |
| Y N Kidney trouble | Y N Tuberculosis |
| Y N Persistent cough | Y N Frequent colds or sore throats |
| Y N Frequent headaches | Y N Stomach ulcer or hyperacidity |
| Y N Tumor (cancerous or benign) | Y N Radiation therapy or chemotherapy |
| Y N Tonsils or adenoids removed? What age? _____ | Y N Is patient's height and weight normal for his/her age? |
| Y N Cardiovascular disease (heart trouble, heart attack, angina, high blood pressure, arteriosclerosis, stroke) | |
| Y N Damaged or artificial heart valves including heart murmur or rheumatic heart disease | |
| Y N Does the patient have any disease, condition, or problem not listed above that you think we should know about? If so, please explain _____ | |

Have you been informed of any missing or extra permanent teeth? Yes No

Have there been injuries to the patient's face, mouth, or chin? Yes No If yes, please explain _____

Has the patient ever had pain/tenderness in the jaw joint (TMJ/TMD)? Yes No

Does/did the patient have any of the following habits?

Grinding teeth Finger/thumb sucking Prolonged bottle/pacifier use

Mouth breather Speech problems Chewing/eating problems

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits.

Signature _____

Date _____