WELCOME TO WAKHAM ORTHODONTICS

The following information is requested to enable me to give your child the best consideration of their orthodontic problem during their initial examination in our office. In order for me to thoroughly diagnose any condition, I must have accurate background and health information on which to base my decisions. This information, which is important for my records and your health, is confidential. Thank You.

Patient's Name _____ (LAST FIRST MIDDLE NICKNAME) Age _____ Date of Birth _____ Sex _____

Home Address _____ (STREET CITY ZIP CODE)

Home Phone _____ Mother's Cell _____ Father's cell _____

Email: _____

School _____ Grade _____ Other Telephone Number for Emergency _____

Patient's Physician _____ Patient's Dentist _____ Referred By _____

Father's Full Name _____ Mother's Full Name _____

Father's Birthday _____ Mother's Birthday _____

Father's Soc. Sec. # _____ Mother's Soc. Sec. # _____

Father Employed By _____ Mother Employed By _____

Position/Occupation _____ Position/Occupation _____

Business Address _____ Business Address _____

Work Telephone Number _____ Work Telephone Number _____

Is Patient Living with Both Parents? _____ If No, With Whom? _____

Person(s) Responsible For Account _____ Orthodontic Insurance _____

Address (if other than above) _____ Phone _____

Employer _____ Social Sec. # _____ Date of Birth _____

MEDICAL HISTORY: Circle those that apply

Asthma	Diabetes	Heart Disease	Rheumatic Fever
Anemia	Epilepsy	Hearing Disorder	Speech Disorder
Blood Disease	Endocrine Problems	Head or Face Injury	Risk Group for AIDS
Bone Disorder	Emotional Problems	Hepatitis	Other (describe below)

COMMENTS: _____

Has the patient been under the care of a physician during the past two years, other than for routine examination? ..... YES NO

WHY? _____

Present drugs or medication: _____

Birth Defects: _____

Has the patient reached puberty? ..... YES NO

Does the patient have any severe emotional or mental disturbance? ..... YES NO

If yes, briefly describe: _____

_____

RESPIRATORY HISTORY:

Does the Patient:

1. Have allergies to: Seasonal grasses _____ Food _____
   Drugs _____ Other _____
2. Snore when sleeping? ..... YES NO
3. Breathe through mouth? ..... Seldom Sometimes Usually
4. Have frequent colds? ..... YES NO
5. Have frequent "stuffy nose or sore throat"? ..... YES NO
6. Have chewing or swallowing difficulty? ..... YES NO

Has the patient received medical treatment from allergist or ear, nose and throat specialist? ..... YES NO

If Yes, When _____ By Whom _____

For What _____

(Complete Reverse Side)

DENTAL HISTORY:

Does the patient have pain or clicking in jaw joint? ..... YES NO

Have any teeth been injured due to accidents or blows to the mouth? ..... YES NO

Has the patient received or been requested to receive speech correction? ..... YES NO

The following habits are of interest. List information as it pertains to this patient?

Thumb sucking until age _____ Grinding of teeth ..... YES NO

Finger sucking until age _____ Tongue thrusting ..... YES NO

Lip-biting or sucking ..... YES NO Other habits ..... YES NO

Has the patient had any unusual dental experiences? ..... YES NO

If so, what happened? _____

_____

_____

Date of last dental check up _____ Were the patient's teeth cleaned? YES NO

Have any teeth been extracted with the intent of making more space for other teeth to erupt? ..... YES NO

If so, by whom and approximately when? Doctor _____ Year _____

Has the patient ever worn space maintainers? ..... YES NO

Has the patient ever worn braces? ..... YES NO

If so, under whose care? Doctor _____ When _____

Has the patient ever seen another orthodontist? ..... YES NO

Do both parents have straight teeth? ..... YES NO

Has either parent had his/her teeth straightened? Father _____ Mother _____

Has patient's brother or sister had his/her teeth straightened? ..... YES NO

Whom do you think the patient's face most resembles?

Mother? _____ Father? _____ Combination? _____

Height of patient's mother: _____ feet _____ inches Height of patient's father: _____ feet _____ inches

Is the patient an adopted child? ..... YES NO

Names and ages of other children in family? _____

_____

What type of student is the patient? Excellent _____ Good _____ Average _____ Poor _____

What are the patient's hobbies or interests? _____

Does the patient play a musical instrument with his/her mouth? ..... YES NO

If so, which instrument? _____ How long has he/she played? _____

What do you think is wrong with your child's teeth? _____

_____

_____

Is your child concerned about the appearance of his/her teeth? ..... YES NO

Does your child want straight teeth? ..... YES NO

The above information is complete and correct to the best of my knowledge.

Signed _____ Date _____