BLAIS ORTHODONTICS

CHILD'S ORTHODONTIC FORM

Date_____

Patient's name _____
Last First Middle

Address

_____
Street City Zip

Nickname_____ Birthdate_____

School & Grade _____ Sports/Hobbies _____

Parent or guardian name _____

Patient's Dentist_____
Pediatrician_____

Names and Ages of other children in family_____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Mother's Name

_____
Last First Middle

Father's Name _____
Last First Middle

Home phone_____ Work phone

_____

Cell/other phone_____ Email address _____

Mailing Address for Billing (if different than above) _____

MEDICAL HISTORY

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient in good health? _____

Yes No Does the patient have any history of major illness? _____

Yes No Is the patient taking any medication? _____

Yes No Is the patient allergic to any medication? _____

Yes No Has the patient had any operations? _____

Yes No Ever been involved in a serious accident? _____

Yes No Have seen a physician in the last 12 months? Why? _____

Yes No Does patient have tendency to have colds, sore throats or ear infections? _____

Yes No Have tonsils and adenoids been removed? If so, what age? _____

Yes No Are all of the members of your family currently in good health?_____

Yes No Does anyone in your family have an elevated temperature?_____

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Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

DENTAL HISTORY

Yes No Is the patient presently in any dental pain? _____

Yes No Ever experienced any unfavorable reaction to dentistry? _____

Yes No Has the patient ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth, or teeth? _____

Yes No Is any part of your mouth sensitive to temperature? Where? _____

Yes No Is any part of your mouth sensitive to pressure? Where? _____

Yes No Do gums bleed when brushing? _____

Yes No Any type of thumb or tongue habit? Until what age? _____

Yes No Is the patient a mouth breather? _____

Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____

Yes No Has anyone in the family received orthodontic treatment?_____

How did they feel about the result? _____

Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____

Yes No Experience jaw clicking or popping? _____

Yes No Aware of clenching or grinding teeth during the day? _____

Yes No Experience “tension” headaches? _____

Yes No Has the patient ever experienced chronic ringing in the ears? _____

Yes No Is the patient sensitive or self-conscious about his/her teeth? _____

Parent’s Signature: _____