downers grove ORTHODONTICS™

PATIENT INFORMATION
FOR PATIENTS UNDER 18 YEARS

Date ___/___/___

Patient Last Name	Patient First Name	Patient Middle Name	Gender ○M ○F

Nickname	Date of Birth ___/___/___	Age	Social Security Number (SSN) ___-___-___

Home Address	City	State	Zip

School	Sports / Hobbies

List musical instruments played

Full name of person accompanying patient today	Relationship to the patient

Do you have legal custody of the patient ○ Yes ○ No	If no, who is the patient's legal guardian (Full Name)

Who may we Thank for referring you to our office?

RESPONSIBLE PARTY

Last Name	First Name	Middle Name

Home Address (If different from the patient's Home Address)	City	State	Zip

Mailing Address (If different from Home Address)	City	State	Zip

How Long (Years)	Home Phone	Work Phone	Cell Phone

Email Address	Relationship to the patient

Previous Address (If less than 3 years at current residence)	City	State	Zip

Date of Birth ___/___/___	Social Security Number (SSN) ___-___-___	Marital Status ○Single ○Married ○Widowed ○Separated ○Divorced ○Partnered

Employer	Occupation	How Long Employed (Years)

Employer Address	Employer Phone

Spouse's Name	Spouse's Relationship to patient

Spouse Employer	Spouse Occupation	Spouse Employed (Years)

Spouse Employer Address	Spouse Employer Phone

Spouse Cell Phone	Spouse Date of Birth ___/___/___	Spouse Social Security Number (SSN) ___-___-___

Spouse Email	Spouse Work Phone

PRIMARY ORTHODONTIC INSURANCE INFORMATION

Member Name	Group Number	Member SSN or Member ID

Insurance Company	Insurance Phone	Local Number

SECONDARY ORTHODONTIC INSURANCE INFORMATION

Member Name	Group Number	Member SSN or Member ID

Insurance Company	Insurance Phone	Local Number

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you	Relative's Phone

Relative Address	City	State	Zip

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

Signature of Parent or Guardian _____ **Date** ___/___/___

Printed Name _____

Updates Date ___/___/___ Initial _____ Date ___/___/___ Initial _____

DGO20120907

MEDICAL HISTORY

Physician's Name (First and Last) | Date of Last Visit

Physician's Address | Physician's Phone

Is the patient taking any medication? ○ Yes ○ No | List medications:

Is the patient allergic to any medication? ○ Yes ○ No | List medications:

Has the patient had any operations? ○ Yes ○ No | Details:

Has the patient ever been involved in a serious accident? ○ Yes ○ No | Details:

Has the patient seen a physician in the last 12 months? ○ Yes ○ No | Why?

Is the patient allergic to latex? ○ Yes ○ No | Details:

Is the patient allergic to metals / nickel? ○ Yes ○ No | Details:

Is the patient allergic to plastics? ○ Yes ○ No | Details:

Has puberty begun? ○ Yes ○ No

FEMALES ONLY	Has menstruation started? ○ Yes ○ No	Is the the patient pregnant? ○ Yes ○ No	Week #	

PLEASE CHECK (X) IF THE PATIENT HAS HAD ANY OF THE FOLLOWING

☐ Abnormal Bleeding / Hemophilia	☐ Diabetes	☐ Hepatitis / Liver Problems	☐ Pneumonia
☐ ADD / ADHD	☐ Dizziness	☐ Herpes	☐ Prolonged Bleeding
☐ Anemia	☐ Epilepsy / Fainting	☐ High Blood Pressure	☐ Psychiatric Problems
☐ Arthritis	☐ Gastrointestinal Disorders	☐ HIV+ / AIDS	☐ Radiation / Chemotherapy
☐ Artificial Bones / Joints / Valves	☐ Handicaps / Disabilities	☐ Kidney problems	☐ Rheumatic / Scarlet Fever
☐ Asthma or Hayfever	☐ Heart Murmur	☐ Lupus	☐ Tuberculosis (TB)
☐ Bone Disorders	☐ Heart Problems	☐ Nervous Disorders	☐ Tumor or Cancer
☐ Congenital Heart Defect			

Does the patient have any **other medical conditions** not listed we should be aware of? ○ Yes ○ No | Details:

DENTAL HISTORY

Dentist Name (First and Last) | Date of Last Visit

Dentist Address | Dentist Phone

What concerns you most about the patient's teeth?

Is the patient presently in any dental pain? ○ Yes ○ No | Details:

Has the patient ever experienced any unfavorable reaction to dentistry? ○ Yes ○ No | Details:

Have the patient ever lost or chipped any teeth? ○ Yes ○ No | Details:

Have there been any injuries to face, mouth, teeth or jaw? ○ Yes ○ No | Details:

Have adenoids or tonsils been removed? ○ Yes ○ No | Details:

Does the patient brush his / her teeth daily? ○ Yes ○ No | Details:

Does the patient floss his / her teeth daily? ○ Yes ○ No | Details:

Do the patient's gums bleed when brushing? ○ Yes ○ No | Details:

Does the patient have any type of thumb or tongue habit? ○ Yes ○ No | Details:

Does the patient generally breathe through the mouth? ○ Yes ○ No | Details:

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

Does the patient experience jaw clicking or popping? ○ Yes ○ No | Details:

Is the patient aware of clenching or grinding teeth during the day? ○ Yes ○ No | Details:

Does the patient need extra help with instructions? ○ Yes ○ No | Details:

If the the patient is under age 16, height of parents? Mother | Father

Are you aware that some appointments will be during work / school hours? ○ Yes ○ No

BENEFITS OF ORTHODONTICS: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

In addition, I authorize Dr. Balakrishnan and her staff to perform a complete orthodontic evaluation of the patient.

Signature of Parent or Guardian _____ **Date** ___/___/___

Doctor's Comments _____

_____ **Initials** _____ **Date** ___/___/___