

RAMPTON Orthodontics

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Patient Information - Minor

Patient's Name _____ Preferred Name _____ Sex: ___ M ___ F
Address _____ City _____ State _____ Zip _____
Birth date _____ Age _____ School _____ Grade _____
Home Phone (____) _____ Cell (____) _____ Best Phone Contact: ___ Home ___ Cell
Patient's E-Mail Address (if they want to receive reminders) _____
Child lives with: ___ Both Parents ___ Mother ___ Father ___ Other/Whom: _____
Name of closest relative *not* living with you _____ Phone _____ Relationship _____
Names of *immediate* family members treated here _____
If this is your first consult in our office, who referred you or how did you learn about us? _____
Patient's Dentist _____ City _____

What is your chief concern with patient's teeth? _____

Patient's special interests, talents or hobbies _____

Responsible Party Information

Name of Person responsible for Patient Account _____ Relationship _____
Father's Name _____ Mother's Name _____
Employed by _____ Employed by _____
Occupation _____ Occupation _____
Home Address _____ Business Address _____
Cell (____) _____ Business (____) _____ Business Phone (____) _____
Social Security Number _____ - _____ - _____ Social Security Number _____ - _____ - _____
E-Mail _____ E-Mail _____
Birth date _____ Birth date _____
Parent(s) are/is: ___ Married ___ Separated ___ Divorced ___ Widowed ___ Single

Orthodontic Insurance Information - If *No* Insurance check here ___

PRIMARY Insurance Information:

Name of Insured _____ Relationship to Patient _____
Birth date of Insured _____ Social Security Number _____ - _____ - _____ or I.D. # _____
Employer _____ Business Address _____
Insurance Company _____ Group # _____ Ins. Phone (____) _____
Insurance Address _____ City _____ State _____ Zip _____
Ortho Lifetime Maximum \$ _____ Used to date \$ _____ Effective date _____ Called to confirm _____

SECONDARY Insurance Information:

Name of Insured _____ Relationship to Patient _____
Birth date of Insured _____ Social Security Number _____ - _____ - _____ or I.D. # _____
Employer _____ Business Address _____
Insurance Company _____ Group # _____ Ins. Phone (____) _____
Insurance Address _____ City _____ State _____ Zip _____
Ortho Lifetime Maximum \$ _____ Used to date \$ _____ Effective date _____ Called to confirm _____

-Please complete other side-

Health and Dental History

Patient's Medical Physician _____ City _____

Does/Has the Patient:

- | | | |
|-----|-----|---|
| Yes | No | |
| ___ | ___ | Have any health problems? Explain _____ |
| ___ | ___ | Take any medications? List _____ |
| ___ | ___ | Have allergic reactions to medications? List _____ |
| ___ | ___ | Currently seeing a physician, other than well child checks? Explain _____ |
| ___ | ___ | Received blood transfusions? Reason _____ |
| ___ | ___ | Had tonsils and adenoids removed? When _____ |
| ___ | ___ | Take medication for immunosuppressive disease? Explain _____ |
| ___ | ___ | Take any medications for dietary conditions? Explain _____ |
| ___ | ___ | Have Hay fever or Seasonal Allergies? Explain _____ |
| ___ | ___ | Have Sinus problems? Explain _____ |

Has Patient ever had::

- | Yes | No | | Yes | No | | Yes | No | |
|-----|-----|---------------------------------|-----|-----|------------------------------|-----|-----|----------------------|
| ___ | ___ | Heart Murmur | ___ | ___ | Nervousness/Anxiety | ___ | ___ | Thumb/Finger Sucking |
| ___ | ___ | Rheumatic Fever | ___ | ___ | Emotional/Depression Problem | ___ | ___ | Mouth Breathing |
| ___ | ___ | Heart Surgery | ___ | ___ | Fainting/Dizziness | ___ | ___ | Nail Biting |
| ___ | ___ | High Blood Pressure | ___ | ___ | Epilepsy/Seizures | ___ | ___ | Speech Problems |
| ___ | ___ | Blood/Bleeding Disorder | ___ | ___ | Asthma | ___ | ___ | Teeth Grinding |
| ___ | ___ | Bone Disorder | ___ | ___ | Hives/Rash/Allergic Reaction | ___ | ___ | Teeth Clenching |
| ___ | ___ | Osteoporosis | ___ | ___ | Arthritis/Rheumatism | ___ | ___ | Jaw Popping |
| ___ | ___ | Paget's Disease | ___ | ___ | Cancer | ___ | ___ | Jaw Locking |
| ___ | ___ | Growth Disorder | ___ | ___ | Diabetes | ___ | ___ | Jaw Pain |
| ___ | ___ | Developmental Disorder | ___ | ___ | Kidney Disease | ___ | ___ | Frequent Headaches |
| ___ | ___ | Endocrine Disorder | ___ | ___ | Tuberculosis | ___ | ___ | ringing in Ears |
| ___ | ___ | Attention Deficit/Hyperactivity | ___ | ___ | Pregnancy (Current/Recent) | ___ | ___ | Pain in Head/Neck |

Other conditions, impairments or problems: _____

Growth information for patients under 16 – Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to plan our treatment alternatives: Has the patient:

- | | | |
|-----|-----|---|
| Yes | No | |
| ___ | ___ | Reached puberty? |
| ___ | ___ | Do you feel growth is completed? Patient's Height _____ Father's Height _____ Mother's Height _____ |
| ___ | ___ | Have siblings or parents had orthodontic treatment? |

Frequency of dental checkups: Twice/yr ___ Once/yr ___ Infrequent ___ Never ___ Date of last visit _____

- | | | |
|-----|-----|--|
| Yes | No | |
| ___ | ___ | Is there any unfinished care to be completed with your dentist? Explain: _____ |
| ___ | ___ | Have you had any unpleasant dental experiences? Explain: _____ |
| ___ | ___ | Are you frightened about orthodontic treatment? Explain: _____ |
| ___ | ___ | Have you had any face or dental injuries? Explain: _____ |
| ___ | ___ | Do you play any musical instrument using the mouth? What Instrument? _____ |
| ___ | ___ | Have you consulted with an orthodontist previously? With Whom? _____ |
| ___ | ___ | Have you had any previous orthodontic treatment? With Whom? _____ |
| ___ | ___ | Are you aware of missing or extra permanent teeth? Explain: _____ |
| ___ | ___ | Are you satisfied with prior orthodontic treatment? Explain: _____ |

Is there any other information that may be helpful? _____

Parent/Guardian's Signature _____ Relationship to Patient _____ Date _____

For Office Use Only: This medical/dental information has been verbally reviewed/updated with the parent:

Date _____ T.C. Initials _____ Parent Initials _____ Doctor Initials _____