CARMEL Orthodontics

Welcome!

1st Visit Date_____ PATIENT NAME:_____
LAST *FIRST* *M.I.*

Male___ Female___ Age_____ Date of Birth _____ School_____ Grade_____

Home Address_____City_____ Zip_____

Home Phone #_____ Cell Phone #_____ Email Address_____

Referred by_____Patient's Dentist_____ Last visit_____

Patient's Physician_____ Oral Surgeon_____

Father's Name_____ SS#_____

Occupation_____ Employer_____

Business Address_____ Business Phone_____

Mother's Name_____ SS#_____

Occupation_____ Employer_____

Business Address_____ Business Phone_____

If parents are separated or divorced, who has financial responsibility?_____

Phone #_____ Address_____ City_____ Zip_____

HEALTH HISTORY: Is the patient in good health? YES___ NO___ If no, please explain:

_____

Does the patient have a history of major illness or injury? YES___ NO___ If yes, please describe:

_____

Has the patient ever been treated for: Rheumatic Fever Hepatitis HIV Heart Problem Glaucoma

LIST ANY CURRENT DRUGS/MEDICATIONS:_____

LIST ANY DRUG ALLERGIES OR SENSITIVITIES:_____

Have the patient's tonsils or adenoids been removed? YES___ NO___ If so, when?_____

Has the patient reached adolescent growth? YES___ NO___
GIRLS: If monthly cycle has started, when?_____
BOYS: If voice has changed, when?_____

Patient's height: ___ft ___in
Father's height: ___ft ___in
Mother's height: ___ft ___in

Names & Ages of Brothers & Sisters_____

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH, OR TEETH? YES___ NO____ If yes, please explain:

_____

Does the patient play any musical instruments? If yes, which one(s)?_____

Does the patient normally breathe through his/her (While awake): _____ Mouth or _____ Nose?
(While asleep): _____ Mouth or _____ Nose?

HAS THE PATIENT HAD A HISTORY OF SUCKING A THUMB/FINGER? NO____ YES____ Until what age?_____

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA TEETH?_____

Does the patient have any history of gum disease?_____ Clicking, popping or jaw pain?_____

Have you previously consulted with an Orthodontist?_____

PRIMARY REASON FOR CONSULTATION_____

Has any member of your family ever been seen in this office? If yes, who?_____

Date_____ Signature_____