

Parks Orthodontics

Child Information and Health History

Date: _____ Chart # _____

status _____
 xray _____ diag. _____ tx. _____ info. _____
 insurance _____

Patient Information

Last Name		First Name		Name to be called		Birthdate	Age	Sex
Street Address (where patient resides- No PO Box)			City	State	Zip	Home phone No.		
Parent Email Address:			School		Parent cell phone No.			
			Grade					
In case of emergency please notify		Relationship to Patient		Phone No.		How did you hear about our office?		
Siblings				Age		Patient's Hobbies/ Special Interests		
Relatives who are (were) patients								

Parent Information

Patient lives with		<input type="checkbox"/> Mother		<input type="checkbox"/> Father		<input type="checkbox"/> Both Parents		<input type="checkbox"/> Other (Describe)		Who will pay patient portion of fees (not insurance)?	
Parent's Marital Status		<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Separated		<input type="checkbox"/> Single		<input type="checkbox"/> Widowed <input type="checkbox"/> Remarried	
Mother's Name			Date of Birth			Father's Name			Date of Birth		
Street Address			Rent <input type="checkbox"/>		Own <input type="checkbox"/>		How Long?		Street Address (if different than above)		
			Rent <input type="checkbox"/>		Own <input type="checkbox"/>		How Long?				
City			State		Zip		City			State Zip	
Social Security #			Home Phone			Social Security #			Home Phone		
Employer		How Long?		Work Phone		Employer		How Long?		Work Phone	
Position		Cell Phone		Position		Cell Phone		Position		Cell Phone	

Financial Information

Name of person who will be paying this account			Relationship to Patient		
Street Address (if different than above)			City		State Zip
Employer		Social Security #		Home Phone	
				Work Phone	

Responsible Party Signature		Date
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Please complete medical and dental history on the reverse of this form

Medical History

Family Physician

Check any of the following the patient has experienced:

Heart Problem HIV
 Diabetes Hepatitis
 Rheumatic Fever Anemia

for items checked, please provide more detailed description below

List any serious illness or hospitalization:

Allergies:

List medications the patient is currently taking:

Are any of the above related to osteoporosis or any other bone related condition? yes no
 If yes, which?

Is the patient pregnant? yes no

Describe any of the above mentioned conditions:

Dental History

Family Dentist _____ **Last check-up** _____

Tell us what you do not like about your teeth:

Check any of the following that patient has experienced:

Jaw clenching or grinding Lip biting
 Pain while chewing Ice chewing
 Finger or thumbsucking Nail biting
 Gum Chewing Smoking
 Tooth Pain
 Where? _____

Periodontal (gum) disease
 Describe _____

Wisdom teeth removed
 How many? _____

Injury to mouth or teeth
 Describe _____

Head or neck injury or surgery
 Describe _____

Chin or jaw injury
 Describe _____

What orthodontic treatment (if any) have you received prior?

Have you seen another orthodontist for a consultation?
 If yes, who? _____

*****OFFICE USE*****

Diagnostic Findings

Direct Examination			X-Ray Findings		Cast Analysis		Special		
Molar Relation	Right	Left	Supernum. Teeth	_____	Overbite	_____	Overjet	_____	<input type="checkbox"/> Surgery Class III or Class II
Canine Relation	Right	Left	Missing Teeth	_____	Curve of Spee	_____			<input type="checkbox"/> Elastics w/ Braces
Upper Midline	Lower Midline		3rd Molars	_____	Cross Bite	_____			<input type="checkbox"/> Elastics w/ Invisalign
Prematurities			Impacted Teeth	_____	Teeth Present	_____			<input type="checkbox"/> Distal Jet
TMJ			Root Resorption	_____	Rotations	_____			<input type="checkbox"/> Ectopic teeth
Facial Asymmetry			Carious Lesions	_____	Arch Form	_____			<input type="checkbox"/> Implant
Profile			Ceph	_____	Malformations	_____			<input type="checkbox"/> Safety incisor retraction
Lip Posture	Lip Line		Other	_____	Upper Crowding	_____			<input type="checkbox"/> Vertical Grower
Abnormal Frenum			Pain	_____	Lower Crowding	_____			<input type="checkbox"/> Missing lower anteriors
Oral Hygiene	Gingival Recession		Maximun Opening	_____	Occlusor Wear	_____			<input type="checkbox"/> Missing Lats -close space
Treatment Objectives:					Patient's main concern:				<input type="checkbox"/> Missing Lats - open space
Appliances to be used:					Notes:				<input type="checkbox"/> HEMISection of lower Es
									<input type="checkbox"/> Retain decidous teeth
									<input type="checkbox"/> Impacted 1st & 2nd Molars
									<input type="checkbox"/> Ankylosed teeth