

# PATIENT INFORMATION FORM

Welcome to our office...  
Please assist us by completing the following questions...

Date \_\_\_\_\_

Patient's name \_\_\_\_\_ Nickname \_\_\_\_\_  
 Res. address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of birth \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
 Patient's dentist \_\_\_\_\_ Address \_\_\_\_\_  
 Physician \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_  
 Father's name \_\_\_\_\_ Social security no. \_\_\_\_\_ Bus. telephone \_\_\_\_\_  
 Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer's address \_\_\_\_\_  
 Mother's name \_\_\_\_\_ Social security no. \_\_\_\_\_ Bus. telephone \_\_\_\_\_  
 Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer's address \_\_\_\_\_  
 Person responsible for this account \_\_\_\_\_ Parents' marital status \_\_\_\_\_ Social security no. \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Do you have an insurance plan which covers orthodontic treatment?  Yes  No Name of company \_\_\_\_\_  
 Names and ages of other children in family \_\_\_\_\_  
 List any musical instruments played, hobbies or special interests \_\_\_\_\_

## MEDICAL HISTORY

	YES	NO	?
Is patient in good health? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does patient have any history of major illness? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Check any of the following for which the patient has been treated:

DIABETES ..... <input type="checkbox"/>	ANEMIA ..... <input type="checkbox"/>	PROLONGED BLEEDING .... <input type="checkbox"/>	HEPATITIS ..... <input type="checkbox"/>
PNEUMONIA ..... <input type="checkbox"/>	EPILEPSY ..... <input type="checkbox"/>	FAINING/DIZZINESS ..... <input type="checkbox"/>	HIV ..... <input type="checkbox"/>
HEART TROUBLE ..... <input type="checkbox"/>	ASTHMA ..... <input type="checkbox"/>	NERVOUS DISORDERS ..... <input type="checkbox"/>	OTHERS NOT LISTED ..... <input type="checkbox"/>
RHEUMATIC FEVER ..... <input type="checkbox"/>	KIDNEY INVOLVEMENT ..... <input type="checkbox"/>	LIVER INVOLVEMENT ..... <input type="checkbox"/>	
BONE DISORDERS ..... <input type="checkbox"/>	TUBERCULOSIS ..... <input type="checkbox"/>	ENDOCRINE PROBLEMS ... <input type="checkbox"/>	

Does patient have tendency to:  colds  sore throat  ear infections? \_\_\_\_\_

Have tonsils and adenoids been removed? What age? \_\_\_\_\_

Any other operations? \_\_\_\_\_

List any drugs or medications now being taken (give reasons) \_\_\_\_\_

List any allergies or drug sensitivity \_\_\_\_\_

Mental development \_\_\_\_\_ Emotional attitude \_\_\_\_\_ Has patient reached puberty?

Height \_\_\_\_\_ Weight \_\_\_\_\_ Patient most resembles:  Mother  Father  Both

Has patient seen a physician in last 2 years? Date of last physical exam \_\_\_\_\_

If yes, why? \_\_\_\_\_

## DENTAL HISTORY

Does patient vomit, gag or faint easily? \_\_\_\_\_

Is patient a mouth breather?  while awake  while asleep \_\_\_\_\_

Has there been any injuries to the face, mouth or teeth? \_\_\_\_\_

Has the patient ever sucked a thumb or finger? Until what age? \_\_\_\_\_

Does the patient have any speech problems? \_\_\_\_\_

Has patient had any clicking or discomfort in jaw joints near ears? \_\_\_\_\_

Have you been informed of any missing or extra permanent teeth? \_\_\_\_\_

Does the patient clench or grind his/her teeth? \_\_\_\_\_

When did the patient last see his/her dentist? \_\_\_\_\_ Were any x-rays taken?

How many times a day does patient brush teeth? \_\_\_\_\_

Has there been previous orthodontic treatment in family? \_\_\_\_\_

Reason for orthodontic examinations: \_\_\_\_\_

\_\_\_\_\_  
PARENT'S SIGNATURE

**BENSON MONASTERSKY, D.M.D.**

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Member  
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