PINE ORTHODONTICS
CHOOSE US and Smile

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Welcome! *Our specialty is creating smiles for life. Please provide an answer for each question listed. If the question doesn't apply to you please write/type N/A in the field.*

PATIENT INFORMATION — CHILD

ALL ABOUT YOUR CHILD

Name:_____
LAST FIRST MI

Nickname: _____

Male ☐ Female ☐ Birthdate:_____/_____/_____ Age: _____

School:_____ Grade: _____

Hobbies/Sports: _____

Child's Home #: _____

Child's Home Address: _____

City: _____ State:_____ Zip:_____

DENTIST

General Dentist: _____ Date of Last Exam: _____

What are your main concerns that you would like orthodontics to accomplish?: _____

_____

Has your child ever had or been evaluated for orthodontic treatment? Yes ☐ No ☐
If yes by whom: _____ City & State: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY

Name:_____ Relation: _____

Parent's Marital Status:_____ Do you have legal custody of this child?: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

_____

Mother ☐ Step Mother ☐ Guardian ☐

Name:_____
LAST FIRST

Birthdate:_____/_____/ _____

Cell # _____ Home #: _____ Work #: _____ Ext: _____

Email: _____

Employer:_____

How long at current job?: _____ Title:_____

Do you have dental insurance with orthodontic coverage? Yes ☐ No ☐

Father ☐ Step Father ☐ Guardian ☐

Name:_____
LAST FIRST

Birthdate:_____/_____/ _____

Cell # _____ Home #: _____ Work #: _____ Ext: _____

Email: _____

Employer:_____

How long at current job?: _____ Title:_____

Do you have dental insurance with orthodontic coverage? Yes ☐ No ☐

Who will be responsible for making appointment? _____

Who will be responsible for the account? _____

MEDICAL HISTORY **PHYSICIAN NAME:** _____ **CITY**_____

Does the patient have a history of the following medical conditions? Check Yes or No on each.

AIDS/HIV	☐ Yes	☐ No	Drug Allergies	☐ Yes	☐ No	Muscular Disorders	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Endocrine Problems	☐ Yes	☐ No	Nervous Disorders	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Emotional Disorders	☐ Yes	☐ No	Organ Transplant	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Plastic Allergy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fainting/Dizziness	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Autism/Aspergers	☐ Yes	☐ No	Handicap/Disability	☐ Yes	☐ No	Prolonged Bleeding	☐ Yes	☐ No
Bone Disorders	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Heart Condition/Murmur	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No	High/Low Blood Pressure	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Cold Sores/Herpes	☐ Yes	☐ No	Immune Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No			
Down Syndrome	☐ Yes	☐ No	Latex Allergies	☐ Yes	☐ No			

☐ Yes ☐ No Are antibiotics necessary prior to treatment?

Please explain any YES answers from above: _____

_____

_____

Any diseases, problems or allergies not mentioned above? _____

_____

List current prescription and over-the-counter medications: _____

_____

CHECK YES OR NO FOR EACH.

☐ Yes ☐ No Have the tonsils and/or adenoids been removed?

☐ Yes ☐ No Is the patient a mouth breather?

☐ Yes ☐ No Speech problems?

☐ Yes ☐ No Thumb/Finger sucking?

☐ Yes ☐ No Tongue thrust?

☐ Yes ☐ No Nail biting?

☐ Yes ☐ No Lip Sucking/Biting?

☐ Yes ☐ No Soda drinker?

☐ Yes ☐ No Have there ever been any injuries to the face, mouth or teeth? _____

☐ Yes ☐ No Does patient snore?

☐ Yes ☐ No Do gums bleed when brushing?

☐ Yes ☐ No Headaches?

☐ Yes ☐ No Painful chewing?

☐ Yes ☐ No Pain or soreness around face, neck or back?

☐ Yes ☐ No Teeth or jaws uncomfortable?

☐ Yes ☐ No Aware of any clenching of teeth during the day?

☐ Yes ☐ No Grinding teeth?

☐ Yes ☐ No Sensitive to temperature or pressure?

SIGNED CONSENT

I hereby authorize Dr. Pine and his professional team to perform an orthodontic evaluation and consent to the taking of xray films, photographs, and other records (if necessary) to determine appropriate orthodontic treatment on the above-named patient.

I also authorize Dr. Pine's team to leave messages about appointments on my voice mail or answering machine, and agree to receive email reminders and text messages about appointments.

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

Typed Name/Signature:_____ Relationship to Patient:_____ Date: _____