Nettune and Banasiak Orthodontic Associates, P.A.

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Youth Patient History Form

Patient Number _____

Patient's Name _____ Nickname _____ Sex _____ Age _____ Birthdate ____ / ____ / ____
First Middle Last

Patient's Address _____ Home Phone _____ Parent Cell Phone _____

School _____ Parent E-mail _____ Grade _____

Hobbies/Interests _____

Father's Name _____ Home Phone _____ Marital Status _____

Father's Address _____

His Employer _____ Business Phone _____ OK to call at work? ☐ Y ☐ N

Mother's Name _____ Home Phone _____ Marital Status _____

Mother's Address _____

Her Employer _____ Business Phone _____ OK to call at work? ☐ Y ☐ N

Responsible Party's Name _____ Home Phone _____

His/Her Address _____ Relationship _____

Do you have orthodontic dental insurance? ☐ Y ☐ N Group _____ Group # _____

Insurer's Address _____ Referral Source _____

Any family member in TX or treated here? ☐ Y ☐ N Name(s) _____ ( ) _____ ( ) _____ ( )

Your chief concern(s): _____

Dental History

Patient's D.D.S. _____ General Health _____ Last visit to D.D.S. Mos. _____

D.D.S.'s Address _____ Phone _____

Previous Orthodontic TX? ☐ Y ☐ N Length of TX _____ Mos. Parents had Orthodontic TX? ☐ Y ☐ N Mother ☐ Father ☐

Orthodontist's Name _____ Address _____

Oral Habits _____ Breathing Problems _____ Speech & Other Problems _____

Occlusion

Are you aware of pain in the TMJ? ☐ Y ☐ N
Are you aware of popping or clicking? ☐ Y ☐ N
Do you suffer from frequent headaches? ☐ Y ☐ N
Do you grind or clench your teeth? ☐ Y ☐ N
Are you aware of tightness of joints in the morning? ☐ Y ☐ N
Do you have pain or soreness in the eyes? ☐ Y ☐ N
Do your jaws get tired during a meal? ☐ Y ☐ N
Do you have difficulty swallowing? ☐ Y ☐ N
Do you ever have neck or shoulder pain? ☐ Y ☐ N
Other _____

Medical History

Patient M.D. _____

M.D.'s Address _____ Phone _____

Operations: Tonsils Removed ☐ Y ☐ N; Adenoids Removed ☐ Y ☐ N; Other _____

Serious Illness: Heart Trouble ☐ Y ☐ N; Hepatitis ☐ Y ☐ N; Diabetes ☐ Y ☐ N; Epilepsy ☐ Y ☐ N; Kidney/Liver Involvement ☐ Y ☐ N; Gland or Bleeding Disorder ☐ Y ☐ N; Childhood ☐ Y ☐ N; HIV Positive ☐ Y ☐ N; Rheumatic Fever ☐ Y ☐ N

Presently under medical care? ☐ Y ☐ N For what? _____ Your height _____ weight _____

Presently taking medication? ☐ Y ☐ N What Medicine _____ Do you wear contacts ☐ Y ☐ N

Have you ever taken bisphosphonates? ☐ Y ☐ N

Do you have any drug reactions? _____ Allergies? _____

Comments on medical history _____

I, the undersigned, have given the above dental and medical information. I have reviewed it, and find it accurate. If there are any later changes to this history record, I will so inform this practice.

Signature of adult patient/parent _____ Date _____

The above information has been reviewed with the above named individual.

Signature of interviewer _____ Date _____