1 WELCOME TO OUR ORTHODONTIC PRACTICE

Thank you for selecting our office for an evaluation of your child's orthodontic condition. We strive to provide you with the best care possible and work in a traditional family-oriented dental setting. We are committed to meeting or exceeding the standards of patient protection mandated by the Occupational Safety and Health Administration, the Centers for Disease Control, California Dental Association and the American Dental Association. I hope your visit will be informative and helpful. To help us with this evaluation, please fill out these pages. If you have any questions, please ask us – we will be happy to help.

2 PERSONAL INFORMATION

TODAY'S DATE _____

Name _____ Sex _____ Age _____ Date of birth_____

Nickname (likes to be called) _____

Address _____

City, Zip_____ Home phone _____

Email address– for office use only _____

Grade _____ School _____

Sports, musical instruments? _____

Person to contact in case of an emergency _____

Relationship_____ Contact phone _____

Whom may we thank for mentioning our office? _____

Did you visit our website before this appointment? Y N Was that important to your decision? Y N

Has your child had previous orthodontic consultation or treatment? _____

What is the main reason you seek this consultation? _____

_____

_____

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Specialist in Orthodontics and Dentofacial Orthopedics
Orthodontics for Children and Adults
925-934-3583

3 FAMILY INFORMATION (SIBLINGS)

Name _____Age _____

❒ Sister ❒ Brother ❒ Stepsister ❒ Stepbrother

Has had orthodontic treatment ❒ Y ❒ N Orthodontist_____

Name _____Age _____

❒ Sister ❒ Brother ❒ Stepsister ❒ Stepbrother

Has had orthodontic treatment ❒ Y ❒ N Orthodontist_____

4 FAMILY INFORMATION (PARENTS/GUARDIANS)

Name _____Marital status: M S D W (circle)

Relationship_____ Date of Birth _____

Home phone_____ Work phone _____

Employer_____ Occupation_____

Insurance company _____ Social Security #_____

Insurance address _____

Insurance Phone #_____

Name _____Marital status: M S D W (circle)

Relationship_____ Date of Birth _____

Home phone _____ Work phone_____

Employer_____ Occupation_____

Insurance company _____ Social Security #_____

Insurance address _____

Insurance Phone #_____

5 MEDICAL HISTORY

While orthodontic treatments are obviously primarily confined to the mouth, your child's overall health status and medications he/she may be taking do have an effect on oral tissues and the biology of tooth movement. Therefore, we ask that you complete this part of the form and describe or explain questions you answer" yes". Dr. Masuda will review this with you at the examination.

Name of your child's physician_____ Date of last visit_____

Is your child:

Y N Presently under any medical care or taking any medication? Please explain: _____

_____

Y N Allergic to any medications? Latex? _____

Y N Allergic to anything else (including "hay fever")?_____

Has your child had:

Y N His/her tonsils or adenoids removed? At what age? _____

Y N Any serious accident involving head injuries? Please explain_____

Y N Any of the following (please circle):

Rheumatic fever	Attention deficit disorder	Endocrine disorder
Congenital heart lesions	Diabetes	Cancer
Heart trouble	Asthma	Immune system problems
High blood pressure	Tuberculosis (TB)	Hepatitis
Heart murmur	Glaucoma	Other blood borne disease
Heart surgery	Arthritis	Prolonged bleeding
Fainting	Bone disorder	Hemophilia
Epilepsy/convulsions	Neurological disorder	Blood transfusion

Y N Is there other medical history which has not been covered on this form? _____

_____

_____

Y N Are there any matters you would like to discuss in private? _____

_____

6 DENTAL HISTORY

Patient's dentist _____ Date of last dental visit_____

Y N Does your child clench or grind her/his teeth at night?

Y N Does your child breath mainly through his/her mouth?

Y N Does/did your child have any thumb or finger habit? Until what age:_____

Y N Has your child had any primary (baby) teeth removed?

Y N Are you aware of any naturally missing permanent teeth?

Y N Has your child injured or chipped any teeth?

Y N Are you concerned about an underdeveloped or overdeveloped jaw?

Y N For underbites: Is there a relative with an underbite?

Y N Has your child had any injury to his/her head, neck, or jaw?

Y N Is your child aware of clicking, catch, popping or noises in her/his jaw joints? ❒R ❒L ❒Both

Y N Does your child have pain in or about his/her ears, temples, or cheeks?

Y N Does your child have pain or difficulty when chewing, talking, or using her/his jaws?

Y N Does your child's jaw get "stuck," "locked," or "go out"?

Y N Does your child have frequent headaches?

Y N Does your child have any speech difficulties?

Y N Does your child have gums that bleed?

Y N Has your child ever worn a bite plate or other orthodontic appliance?

Y N Does your child take antibiotics before dental procedures?

Y N Is there any other dental related history which might affect orthodontic treatment?

N Y Is it OK to discuss financial matters with your child present?

The information that I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need today. I acknowledge receipt of the Notice of Privacy Practices.

Please sign_____

Relationship_____

Reviewed by_____ Date_____