WELCOME

YOUR CHILD'S INFORMATION

Patient's Name: ____
First Middle Last

Preferred Name (Nickname): ______________________________ Gender: □ Male □ Female

Birthdate: _____/_____/______ Name of school: ______________________ Grade Level:_________

Please list any hobbies or interests: ____

Whom may we thank for referring you to our office?: ___________________________

MEDICAL HISTORY

Physician: ______________________________ Date of Last Visit: __________________

Please check Yes or No (If yes, please fill in details)

Is patient taking any medication? ________________________________ Yes □ No □

Has patient's physician advised prophylactic antibiotics for dental procedures? ________________ Yes □ No □

Is patient allergic to any medication? ________________________________Yes □ No □

Is patient allergic to latex or nickel? Any other allergies?________________________ Yes □ No □

Has patient had any major operations? ________________________________ Yes □ No □

Has patient ever been involved in a serious accident? ________________________ Yes □ No □

Are there any medical conditions we have not discussed that you feel we should be aware of? ______________Yes □ No □

Check any of the medical conditions below that the patient has had or currently has:

- □ Abnormal bleeding/ Hemophilia
- □ Anemia
- □ Arthritis
- □ Asthma or Hayfever
- □ Bone Disorder
- □ Congenital Heart Defect
- □ Diabetes
- □ Dizziness
- □ Radiation/ Chemotherapy
- □ Gastrointestinal Disorders
- □ Heart Problems
- □ Heart Murmur
- □ Hepatitis/ Liver Problems
- □ Herpes
- □ High Blood Pressure
- □ HIV/AIDS
- □ Kidney Problems
- □ Nervous Disorders
- □ Osteoporosis
- □ Pneumonia
- □ Prolonged Bleeding
- □ Epilepsy
- □ Rheumatic Fever
- □ Tuberculosis

DENTAL HISTORY

Current Dentist: ______________________________ Date of Last Visit: ______________

Please check Yes or No (If yes, please fill in details)

Is patient presently in any dental pain? ________________________________ Yes □ No □

Is patient currently seeing any dental specialists? (Periodontist, Prosthodontist, Oral Surgeon)________________ Yes □ No □

Has patient ever experienced any unfavorable reaction to dentistry? ________________________ Yes □ No □

Has patient ever broken or chipped any teeth? ________________________________ Yes □ No □

Have there been any injuries to face, mouth, or teeth? ________________________ Yes □ No □

Is there any part of the patient's mouth sensitive to temperature or pressure? ________________ Yes □ No □

Does the patient's gums bleed when he/she brushes? ________________________ Yes □ No □

DENTAL HISTORY CONTINUED

Does patient have periodontal (gum) problems? ______________________ Yes ☐ No ☐

Does patient have any type of thumb or tongue habit? ______________________ Yes ☐ No ☐

Is there history of a speech problem or therapy? ______________________ Yes ☐ No ☐

Is there history of mouth breathing, snoring, or sleep apnea? ______________________ Yes ☐ No ☐

Has the patient ever seen an orthodontist? If yes, who and when? ______________________ Yes ☐ No ☐

Does the patient's teeth or jaw ever feel uncomfortable when they awake in the morning?______________ Yes ☐ No ☐

Is the patient aware of any jaw clicking or popping? ______________________ Yes ☐ No ☐

Is the patient aware of clenching or grinding his/her teeth during the day? ______________________ Yes ☐ No ☐

Have you ever heard the patient grind his/her teeth at night? ______________________ Yes ☐ No ☐

FAMILY INFORMATION

☐ Same as previously examined sibling: ______________________
First Last

Mother/ Partner Name:______________________
First Last

Occupation: ______________________ Employer: ______________________

Home Address: ______________________
Street City Zip

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

E-mail Address: ______________________

Father/Partner Name:______________________
First Last

Occupation: ______________________ Employer: ______________________

Home Address: ______________________
Street City Zip

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

E-mail Address: ______________________

Parent Status: ☐ Married Step-Mother's Name (If applicable): ______________________
☐ Divorced
☐ Separated Step-Father's Name (If applicable): ______________________

Is patient adopted? ☐ Yes ☐ No How tall is mom?: ______________ How tall is dad?: ______________

Sibling Name: ______________________
First Last

Sibling Name: ______________________
First Last

Sibling Name: ______________________
First Last

Is there a family history of:
☐ Arthritis ☐ Diabetes ☐ Severe Allergies ☐ Unusual Dental Problems ☐ Jaw Size Imbalance

Any other family medical conditions that we should be aware of?: ______________________

____

FINANCIAL INFORMATION

Responsible Billing Party ☐ Father (Above) ☐ Mother (Above) ☐ Other (Please complete below)

Name: ____
First Last

Occupation:___________________________ Employer: ________________________ Years Employed: __________

Home Address: ____
Street City Zip

Home Phone: ______________________ Cell Phone: ______________________ Work Phone: __________________

Do you currently have dental insurance? Yes ☐ No ☐ Not Sure ☐

Does your dental insurance plan include orthodontic coverage? Yes ☐ No ☐ Not Sure ☐

Insured's Name:______________________________ Date of Birth:_____/_____/______ SSN: __________________

Insured's Employer: ____

Insurance Company: _______________________ Group #: _____________________ Insured's ID#_______________

Insurance Co. Claim's Address:____
Street City Zip

What is your primary concern?____

____

____

I have read and understand the above questions. I will not hold my orthodontist or any member of her team responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will promptly inform Ashraf Orthodontics.

Signed: ____ Date: ______________________

Ashraf Orthodontics
children & adults

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