WELCOME TO ASPEN ORTHODONTICS (Patients Under 18 Years)

We strive to make every child's visit pleasant and educational.
Our goal is to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Today's Date:___/___/_____ □ Male □ Female
Child's Name:_____
Last First MI
Nickname:_____ SS#:_____
Child's Birthdate:___/___/___ Child's Age:_____
School:_____ Grade:_____
Hobbies/Sports:_____
Child's Home #:_____
Child's Home Address:_____
_____
City State Zip
Email Address:_____

Who Is With Your Child Today

Name:_____ Relationship:_____
Do you have legal custody of this child? □ Yes □ No
Whom may we thank for referring you?_____
List Brothers/Sisters with age:_____
Other Family Members Seen By Us:_____
_____

Child's Dentist

Name:_____ Last Visit:_____
City, State:_____ Phone: _____

Mother's Information □ Step Mother □ Guardian

Name:_____ Birthdate:_____
Address:_____
Employer:_____ SS#:_____
Work Phone:_____ Home:_____
Email Address:_____ Cell #:_____
Responsible For Account? □ Yes □ No
Responsible For Appointments? □ Yes □ No
Marital Status: □ Married □ Single □ Divorced □Other

Father's Information □ Step Father □ Guardian

Name:_____ Birthdate:_____
Address:_____
Employer:_____ SS#:_____
Work Phone:_____ Home:_____
Email Address:_____ Cell #:_____
Responsible For Account? □ Yes □ No
Responsible For Appointments? □ Yes □ No
Marital Status: □ Married □ Single □ Divorced □Other

Primary Dental Insurance

Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #:_____
Group/Policy #:_____
Orthodontic Coverage? □Yes □ No
Insured's Name:_____
Relationship to Patient:_____
Insured's Birthdate:_____
Insured's Employer:_____
Insured's SS#:_____

Secondary Dental Insurance

Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #:_____
Group/Policy #:_____
Orthodontic Coverage? □Yes □ No
Insured's Name:_____
Relationship to Patient:_____
Insured's Birthdate:_____
Insured's Employer:_____
Insured's SS#:_____

MEDICAL HISTORY

Family Medical History

Do the patient's parents or siblings have any of the following health problems? If so, please explain.
Bleeding disorders_____
Diabetes_____
Arthritis _____
Metabolic Disturbance_____
Severe allergies_____
Unusual dental problems_____
Jaw size imbalance_____
Any other family medical condition we should no about?
_____

Patient Profile

□yes □no □dk/u Does patient follow directions well?
□yes □no □dk/u Does patient brush teeth conscientiously?
□yes □no □dk/u Does patient have learning disabilities or need extra help with instructions?
□yes □no □dk/u Is patient sensitive or self-conscious about teeth?
□yes □no □dk/u Currently have or had substance abuse problems
□yes □no □dk/u Does the patient chew or smoke tobacco?
□yes □no □dk/u Operations? Describe:_____
□yes □no □dk/u Hospitalized? Describe:_____
□yes □no □dk/u Being treated by other health care professional? For:_____
What is physician's name and phone?_____

For medical and dental history questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation. **SEE OTHER SIDE**

Now or in the past, has the patient had:

□yes □no □dk/u Abnormal bleeding or bruising- anemia?
□yes □no □dk/u ADD/ ADHD?
□yes □no □dk/u Any hospital stays?
□yes □no □dk/u Any operations?
□yes □no □dk/u Artificial bones, joints, valves?
□yes □no □dk/u Arthritic or Rheumatoid conditions?
□yes □no □dk/u Asthma?
□yes □no □dk/u Birth defects or hereditary problems?
□yes □no □dk/u Bone fractures, any major accidents?
□yes □no □dk/u Cancer, tumors, or radiation or chemotherapy?
□yes □no □dk/u Chest pain, short of breath or swelling ankles?
□yes □no □dk/u Cardiovascular/blood pressure problems?
□yes □no □dk/u Congenital heart defects, heart murmur?
□yes □no □dk/u Eating disorder?
□yes □no □dk/u Eye, ear, nose, or throat condition?
□yes □no □dk/u Convulsions, epilepsy, or neurological problems?
□yes □no □dk/u Frequent headaches, colds, or sore throats?
□yes □no □dk/u Diabetes?
□yes □no □dk/u Handicaps, disabilities, depression?
□yes □no □dk/u Hearing impairment?
□yes □no □dk/u Hemophilia?
□yes □no □dk/u Hepatitis, jaundice, or liver problem?
□yes □no □dk/u HIV+/AIDS?
□yes □no □dk/u Immune system problems (Lupus, etc)?
□yes □no □dk/u Kidney problems?
□yes □no □dk/u Phen-Fen use?
□yes □no □dk/u Rheumatic/ Scarlet fever?
□yes □no □dk/u Skin disorder?
□yes □no □dk/u Speech, vision, taste, hearing difficulties?
□yes □no □dk/u Stomach ulcers or hyperacidity?
□yes □no □dk/u Tuberculosis (TB), polio, pneumonia, mono?
□yes □no □dk/u Other physical condition or symptoms?
Describe:_____

Allergies or reactions to any of the following:

□yes □no □dk/u Local Anesthetic
□yes □no □dk/u Pain Medications (Aspirin, Ibuprofen, Codeine)
□yes □no □dk/u Antibiotics (Penicillin, etc) or Sulfa
□yes □no □dk/u Metals (jewelry)
□yes □no □dk/u Latex (gloves, balloons), vinyl or acrylic
□yes □no □dk/u Seasonal substances (hayfever, asthma, sinus)
□yes □no □dk/u Other substances (specify)_____

Medications

□yes □no □dk/u Is the patient taking medications, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication_____Taken for_____
Medication_____Taken for_____
Medication_____Taken for_____

GIRLS ONLY

□yes □no □dk/u Has the patient started her monthly periods?
If so, approximately when?_____
□yes □no □dk/u Is the patient pregnant?

DENTAL HISTORY

Now or in the past, has the patient had:

□yes □no □dk/u **Injuries (chips, fractures, etc) to the face, mouth, teeth, or chin?**
□yes □no □dk/u Evaluation for or received orthodontic treatment?
□yes □no □dk/u Early or late eruption of teeth?
□yes □no □dk/u Baby teeth removed that were not loose?
□yes □no □dk/u Permanent teeth removed?
□yes □no □dk/u Mouth infections, bleeding, bad breath?
□yes □no □dk/u Gum boils, cold sores, canker sores
□yes □no □dk/u Adenoids or tonsils been removed?
□yes □no □dk/u History of any extra or missing teeth?
□yes □no □dk/u Periodontal "gum" problems or treatment?
□yes □no □dk/u Fluoride supplements or fluoridated water?
□yes □no □dk/u Difficult problems associated with dental work?
□yes □no □dk/u Difficulty eating or swallowing?
□yes □no □dk/u History of speech problems?
□yes □no □dk/u Been under another dentist's care?

Does/did your child have any of the following habits (circle Y or N)?

Y	N	Speech problems	Y	N	Lip sucking/ biting
Y	N	Nursing bottle	Y	N	Clenching/grinding teeth
Y	N	Mouth breathing	Y	N	Thumb/finger sucking
Y	N	Nail/object biting	Y	N	Tongue Thrust

□yes □no □dk/u **Has your child every had any clicking, popping, pain, or tenderness in jaw joints (TMJ/TMD)?**
□yes □no □dk/u Does your child brush teeth daily?
□yes □no □dk/u Does your child floss teeth daily?
□yes □no □dk/u Is there any dental work that still needs to be done?
□yes □no □dk/u Would the patient object to wearing braces if indicated?

What is your primary concern? Why are you here?_____
How often does your child brush:_____Floss:_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff 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 or dental status, I will so inform this practice. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

Signed:_____Date signed:_____
(Parent or Guardian)

Signed:_____Date signed: _____
(Dental staff member)