DELTA ORTHODONTIC GROUP

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CERTIFIED SPECIALIST IN ORTHODONTICS

WELCOME TO DELTA ORTHODONTIC GROUP - PLEASE COMPLETE THIS FORM WHERE APPLICABLE

INFORMATION FOR PATIENTS WHO ARE MINORS

Patients Name: _____

Home Address: _____
Address City Postal Code

Birth Date: _____ Present Age: _____ Gender: M ❑ F ❑
Month/Day/Year Year /Months

Home Tel. No: ( ) _____ Parent's Cell: ( ) _____ E-mail: _____

Do you have any siblings or relatives who have had treatment at Delta Orthodontic Group? Yes ❑ No ❑

School: _____ Grade: _____

Name	Father	Mother
Address (if different than above)		
Phone no. (if different than above)	( )	( )
Employers Name:		
Business Phone:	( )	( )

Does patient have dental insurance that covers orthodontic treatment? Yes ❑ Plan(s) Name: _____ No ❑

Physician: _____ Dentist: _____ Referred by: _____

Growth information for patients under 16 years of age:

Patient's height: _____ Father's height: _____ Mother's height: _____

Girls: Has she started menstruation? Yes ❑ No ❑ When _____

Boys: Has his voice changed? Yes ❑ No ❑ When _____

Is patient in perfect health? Yes ❑ No ❑ (If no, give reason) _____

Is patient under care of a physician for any reason? Yes ❑ No ❑

(If yes, give reason) _____

Is patient currently taking any medication? Yes ❑ No ❑

(If yes, please list) _____

Does patient have a history of:

Diabetes	Yes ❑	No ❑	Epilepsy	Yes ❑	No ❑
Heart Trouble	Yes ❑	No ❑	Gland or Endocrine Problems	Yes ❑	No ❑
Rheumatic Fever	Yes ❑	No ❑	Fainting or Dizziness	Yes ❑	No ❑
Bone Disorders	Yes ❑	No ❑	Nervous Disorders	Yes ❑	No ❑
Congenital Abnormalities	Yes ❑	No ❑	Emotional Disorders	Yes ❑	No ❑
Tuberculosis	Yes ❑	No ❑	Liver Problems	Yes ❑	No ❑

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Blood Disorders	Yes ❑	No ❑	Hepatitis	Yes ❑	No ❑
Anemia	Yes ❑	No ❑	HIV Infection	Yes ❑	No ❑
Prolonged Bleeding	Yes ❑	No ❑	Kidney Problems	Yes ❑	No ❑
Frequent Colds	Yes ❑	No ❑	Asthma	Yes ❑	No ❑
Ear Infections	Yes ❑	No ❑	Chronic Nasal Obstruction	Yes ❑	No ❑
Frequent Sore Throat	Yes ❑	No ❑	Mouthbreathing	Yes ❑	No ❑
Adenoid Problems	Yes ❑	No ❑	Have Adenoids been removed?	Yes ❑	No ❑
Tonsillitis	Yes ❑	No ❑	Have Tonsils been removed?	Yes ❑	No ❑

Allergies Yes ❑ No ❑

(If yes, please specify) _____

Has patient a history of any other serious illness? Yes ❑ No ❑

(If yes, please specify) _____

Any injuries to the head? Yes ❑ No ❑

(If yes, please specify) _____

Have you been informed of any missing or extra teeth? Yes ❑ No ❑

Have any teeth been extracted? Yes ❑ No ❑

Has an Orthodontist been consulted previously? Yes ❑ No ❑

Has the patient had any orthodontic treatment? Yes ❑ No ❑

Has patient any history of:

Thumbsucking	Yes ❑	No ❑	Until what age _____
Finger sucking	Yes ❑	No ❑	Until what age _____
Lip biting or sucking	Yes ❑	No ❑	Until what age _____
Tongue thrusting			Yes ❑ No ❑
Tooth grinding or clenching			Yes ❑ No ❑
Headaches (frequent)			Yes ❑ No ❑
Muscular soreness around head and neck			Yes ❑ No ❑
Jaw joint soreness			Yes ❑ No ❑
Jaw joint clicking of popping			Yes ❑ No ❑

Has the patient ever received treatment for any of the above problems? Yes ❑ No ❑

(If yes, please specify) _____

Does the patient have regular dental checkups? Yes ❑ No ❑

Date of last checkup: _____

Toothbrushing: After every meal? ❑ Once per day? ❑ Twice per day? ❑

Does the patient floss? Yes ❑ No ❑

Does the patient want treatment? Yes ❑ No ❑ Indifferent _____

Reason for seeking orthodontic consultation: _____

Signed: _____ Date: _____

MEDICAL HISTORY UPDATE:

Signed: _____ Date: _____

Signed: _____ Date: _____