Youth Patient Information and Health Survey

Welcome to our office. Please fill out both sides of form.

Patient's Name _____ Age _____ Birth date _____ Sex☐M F☐

Address _____

Home Phone _____ Cell Phone (adult) _____

Email (adult) _____ School _____ Grade _____

Person responsible for financial matters

Name(s) _____

Address _____

City, State, Zipcode _____

Home Phone _____ Business Phone _____

Place of Employment _____

Social Security Number _____

	Family Dentist	Family Physician	Referred By
Name			
Address			
City, State			

FAMILY AND PATIENT INFORMATION

Father's Name _____ Living? No☐ Yes☐ Occupation _____

Mother's Name _____ Living? No☐ Yes☐ Occupation _____

Parents Marital Status _____ Patient Living with: M☐F☐Both☐ Other _____

Sibling(s) (name & ages) _____

Reason for orthodontic consultation? _____

Has anyone in your family had a similar problem? No☐ Yes☐

Is patient self-conscious about his/her teeth? No☐ Yes☐

Patient's attitude toward orthodontic treatment _____

_____

INSURANCE INFORMATION

Are you covered by insurance for orthodontic treatment? No☐ Yes☐

Insured Name _____ Insured Date of Birth _____

Insured Employer _____ Insured SSN# _____

Insurance Company _____ Insurance ID# _____

Insurance Verification Phone Number _____

Insured Claims Address _____

MEDICAL HISTORY – Has the patient ever had any of the following? (please circle)

☐ AIDS	☐ Bleeding	☐ Emotional Problems	☐ Head or Face Injuries	☐ Oral Ulcer
☐ Allergy	☐ Bone Loss/Disorders	☐ Epilepsy/Seizures	☐ Hepatitis	☐ Previous Surgery
☐ Anemia	☐ Cold Sores	☐ Growth Problems	☐ Herpes	☐ Rheumatic Fever
☐ Arthritis	☐ Diabetes	☐ Hearing Problems	☐ Kidney Disease	☐ Thyroid Problems
☐ Asthma	☐ Endocrine Problems	☐ Heart Condition	☐ Lung Disease	☐ Other (describe below)

Comments _____

Has the patient been under the care of a physician during the past two years, other than for routine examinations? No☐ Yes☐

Condition _____ Date of last medical exam _____

Do you require antibiotic premedication for dental procedures? No☐ Yes☐

Present drugs or medications _____

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RESPIRATORY HISTORY

Do you:

- Have allergies to:
  - Drugs: _____
  - Food: _____
  - Seasonal Grasses: _____
  - Other: _____
- Breathe through mouth? Seldom☐ Sometimes☐ Usually☐
- Snore when sleeping? No☐ Yes☐
- Have frequent colds? No☐ Yes☐
- Have frequent "Stuffy Nose?" No☐ Yes☐
- Have frequent sore throat or tonsillitis? No☐ Yes☐
- Have difficulty chewing or swallowing? No☐ Yes☐

Have you received medical treatment from an allergist or ear, nose, and throat specialist? No☐ Yes☐

If yes: When _____ By Whom _____

Nasal Surgery☐ Tonsils removed☐ Adenoids removed☐

DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY

Has the patient had any unusual dental experiences? No☐ Yes☐

Specify _____

Any injuries to the mouth, teeth or face? No☐ Yes☐

Specify _____

Date of last dental checkup _____ Were the patient's teeth cleaned? No☐ Yes☐

Has the patient had an orthodontic consult or treatment? No☐ Yes☐

Does the patient have Headaches?☐ Neck Pain?☐ Jaw Pain?☐ Ear Pain?☐ Face Pain?☐ Eye Pain?☐ Other?☐

Which side hurts? Right?☐ Left?☐ Both?☐

How long have you had these symptoms?

Years _____ Days _____ Months _____

If yes, please indicate when and where _____

_____

Is the pain constant?☐ Aching?☐ Shooting?☐ Burning?☐ Stabbing?☐ Electrical?☐ Other?☐

Worse in the afternoon?☐ Worse in the morning?☐ Does it hurt to chew?☐ Does it hurt to open wide?☐

Does the patient's jaw ever make a popping noise?☐ Clicking?☐ Grinding?☐ Other?☐

Has the patient's jaw ever "locked" or slipped out of place? No☐ Yes☐

Does the patient ever clench or grind his/her teeth? No☐ Yes☐

During the day?☐ During the night?☐

Does the patient have problems with his/her ears?☐ Hearing?☐ Dizziness?☐ Other?☐

Is it difficult to swallow?☐ Painful?☐

Are the teeth sore or sensitive? No☐ Yes☐

INDICATE HABITS, PAST OR PRESENT

Thumb or Finger Sucking☐ Tongue Thrust (reverse swallowing)☐ Lip Biting☐ Nail Biting☐

Poor speech habits☐ Other☐

Additional comments _____

_____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

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