Bowles Orthodontic Specialists, P.A.

CHILD ORTHODONTIC CONSULTATION

We will appreciate your providing the information requested below.

Date of Birth_________________ _________ _________ Age _________
(month) (day) (year)

Patient's Name ____ Male ______ Female ______

Residence Street Address ____

City ____________________________ State ____________ Zip _______________ Phone _________________________

School ____ Grade in School ____________________________

Patient's Dentist ____ Last Visit _____________________________

Patient's Physician ____ Last Visit ______________________________

Height ____ Weight ____

Whom should we thank for referring you to our office? ____

Has anyone else in your family been treated in this office? ____

Has another orthodontist been consulted previously? ____

In your own words, what is the problem? ____

____

PARENT INFORMATION

Father's Name _______________________________ Mother's Name ____

Father's SSN ________________________________ Mother's SSN ____

Address ____

Father's Employer _____________________________ Mother's Employer ____

Father's Work Phone ___________________________ Mother's Work Phone ______________________________________

Person Responsible for Account: _________________________ Father ___________________________________ Mother

Marital Status (Please Circle) Married Separated Divorced Widowed Single

FINANCIAL INFORMATION

Do you have insurance coverage which includes orthodontic benefits for members of your family ________yes _________no

SIGNED ____ DATE ___________________________________

For all accounts requesting financing in our office, an additional credit check signature is required here: __________________

MEDICAL HISTORY (Circle Answer)

1. Is patient in good health?........ Yes No
2. Has there been any change in patient's general health within the past year?........ Yes No
3. Is patient now under the care of a physician?........ Yes No
   If so, what is the condition being treated? ____________________
4. Has patient had any serious illness, operation, or been hospitalized in the past year?........ Yes No
   If so, what was the illness or problem? ____________________
5. Is patient taking any medicine(s) including non-prescription medicine?........ Yes No
   If so, please list ____________________
6. Has the patient had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease……… Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)……… Yes No Yes No
   c. Allergy……… Yes No
   d. Sinus trouble……… Yes No
   e. Asthma or hay fever……… Yes No
   f. Fainting spells or seizures……… Yes No
   g. Persistant diarrhea or recent weight loss……… Yes No
   h. Diabetes……… Yes No
   i. Hepatitis, jaundice or liver disease……… Yes No
   j. AIDS of HIV infection……… Yes No
   k. Thyroid problems……… Yes No
   l. Respiratory problems, emphysema, bronchitis, etc……… Yes No
   m. Arthritis or painful swollen joints……… Yes No
   n. Stomach ulcer or hyperacidity……… Yes No
   o. Kidney trouble……… Yes No
   p. Tuberculosis……… Yes No
   q. Sexually transmitted disease……… Yes No
   r. Epilepsy or other neurological disease……… Yes No
   s. Problems with mental health……… Yes No
   t. Cancer……… Yes No
   u. Problems of the immune system……… Yes No
7. Has patient experienced abnormal bleeding?........ Yes No
   If so, has patient ever required a blood transfusion?........ Yes No
8. Does patient have any blood disorder such as anemia?........ Yes No
9. Has patient ever had any treatment for a tumor or growth?........ Yes No
10. Is patient allergic or ever had a reaction to any medication?........ Yes No
    If so, list medications causing the allergic reaction ____________________
11. Have tonsils and adenoids been removed?........ Yes No
12. Has patient reached puberty?........ Yes No

DENTAL HISTORY (Circle answer)

13. Have there been any injuries to the face, mouth, or teeth?........ Yes No
14. Has patient ever sucked thumb or fingers? Until what age?______........ Yes No
15. Are there any oral habits, such as lip biting or tongue thrusting?........ Yes No
16. Does patient have any speech problems?........ Yes No
17. Has patient ever had speech therapy?........ Yes No
18. Is patient a mouth breather while asleep or awake?........ Yes No
19. Are you aware of any missing or extra permanent teeth?........ Yes No
20. Would you consider the patient's diet high in sweets?........ Yes No
21. Do patient's gums ever bleed?........ Yes No
22. Does patient clench or grind teeth?........ Yes No
23. Are the teeth sore or sensitive?........ Yes No
24. Have patient's teeth seemed to shift or move recently?........ Yes No
25. Does patient's jaw make a popping or grinding noise?........ Yes No
26. Has patient's jaw ever locked or slipped out of place?........ Yes No
27. Does patient often have Headaches Earaches Jaw Joint Pain Neck Pain……… Yes No

Chief Dental Complaint____________________

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____
Signature of parent or guardian

Bowles Orthodontic Specialists, P.A.

INSURANCE INFORMATION

Insurance Name ____

Insurance Subscriber's Name ____

Subscriber's Member Number or SSN ____

Subscriber's Date of Birth ______________ ___________ _____________
(month) (day) (year)

Subscriber's Employer ____

Subscriber's Work Number ____

Relationship to Patient ____

If you have orthodontic coverage through more than one insurance provider, please list that additional information below.

Insurance Name ____

Insurance Subscriber's Name ____

Subscriber's Member Number or SSN ____

Subscriber's Date of Birth ______________ ___________ _____________
(month) (day) (year)

Subscriber's Employer ____

Subscriber's Work Number ____

Relationship to Patient ____

Member American Association of Orthodontists