Members American Association of Orthodontists

berkman+shapiro orthodontics
Specialists in Orthodontics for Children and Adults

CONFIDENTIAL CHILD ORTHODONTIC PATIENT QUESTIONNAIRE

PATIENT INFORMATION:

Patient's Name: _____ Sex: M F
Last First MI

Preferred Name: _____ Birth Date: _____ Age____ Home Phone: (_____)_____

Address: _____ City: _____

State: _____ Zip: _____ Patient's E-mail Address: _____

Name of School: _____ Grade Level: _____

Hobbies/Interests: _____

Why are you and your child seeking orthodontic treatment? (Please be as specific as possible): _____

_____

Who referred you to our office? _____

FAMILY STATUS:

Father: Mr./Dr._____ Home Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip:_____

Employer: _____ Occupation: _____

Work Phone: (_____)_____ E-Mail Address: _____

Cell Phone: (_____) _____ What number would you prefer we use to contact you? _____

Mother: Mrs./Ms/Dr._____ Home Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip:_____

Employer: _____ Occupation: _____

Work Phone: (_____)_____ E-Mail Address: _____

Cell Phone: (_____) _____ What number would you prefer we use to contact you? _____

Marital status of parents: _____ If divorced, who has custody? _____ Is the patient adopted? _____

Names and birthdates of patient's siblings: _____

_____

Responsible Party: Mr./Mrs./Ms./Dr._____ Home Phone: (_____)_____

Relationship to Patient: _____ If not a parent, do you have legal guardianship?: _____

Address: _____ City: _____ State: _____ Zip:_____

Employer: _____ Occupation: _____

Work Phone: (_____)_____ E-Mail Address: _____

Cell Phone: (_____)_____ What number would you prefer we use to contact you? _____

INSURANCE INFORMATION: Will you be using dental insurance? ___Yes ___ No If yes, please provide the following:

Primary Subscriber: _____ SS# _____

Date of Birth: _____ Employer: _____

Insurance Company: _____ Group # _____ Telephone: (_____)_____

Secondary Subscriber: _____ SS# _____

Date of Birth: _____ Employer: _____

Insurance Company: _____ Group # _____ Telephone: (_____)_____

(QUESTIONNAIRE CONTINUES ON OTHER SIDE OF SHEET)

DENTAL HISTORY:

Patient's Dentist: _____ Phone: (_____) _____

Address: _____

Date of last dental examination and cleaning: _____ Drinking water in the home from: __ City __ Well __ Bottled

Has this patient ever had previous orthodontic treatment or a consultation? ☐Yes ☐No If yes, when? _____

Has another member of the family had orthodontic treatment? ☐Yes ☐No Who?_____

MEDICAL HISTORY:

Family Physician: _____ Phone: (_____) _____

Address: _____

Is the patient currently under a physician's care? ☐Yes ☐No If yes, please explain _____

Is the patient taking any medicine at this time? ☐Yes ☐No Specify: _____

Is the patient currently taking (or has ever taken) any oral or IV bisphosphonate drug *(eg. Actonel® (risedronate), Boniva® (ibandronate), Fosamax® (alendronate), Skelid® (tiludronate), Didronel® (etidronate), Aredia® (pamidronate), Zometa® (zolendronic acid), Bonefos® (clodronate)*? ☐Yes ☐No If yes, reason: _____

Is the patient allergic to any medication? ☐Yes ☐No Specify: _____

Does the patient have any other allergies? ☐Yes ☐No Specify: _____

Has the patient ever been hospitalized? ☐Yes ☐No Females: Is the patient pregnant? ☐Yes ☐No

Does the patient have or has the patient ever had any of the following?

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV+	☐	☐	Birth Defects	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Unfavorable Dental Experience(s)
☐	☐	Anemia	☐	☐	Bleeding Disorder	☐	☐	Epilepsy/Seizures	☐	☐	Injury to Head	☐	☐	Psychological Therapy
☐	☐	Arthritis	☐	☐	Cerebral Palsy	☐	☐	Hearing Problem	☐	☐	Kidney Disease	☐	☐	Radiation or Cancer Therapy
☐	☐	Asthma	☐	☐	Cold Sores	☐	☐	Heart Condition**	☐	☐	Lung Disease	☐	☐	Tonsils/Adenoids Surgery
☐	☐	Oral Ulcers	☐	☐	Rheumatic Fever	☐	☐	Speech Therapy	☐	☐	Previous Surgery	☐	☐	Injury to Face/Teeth/Gums

If the patient has a **heart condition, please specify: _____

Does the patient need to be premedicated (with antibiotics) for routine dental procedures? ___ Yes ___ No
If yes, reason: _____

Does the patient have any other disease, condition, or problem not listed above? Please explain: _____

_____

Doctor's Notes: _____

_____

DOES/DID THE PATIENT:

Grind his/her teeth at night? ☐Yes ☐No Brush his/her teeth: ☐ Often ☐ Occasionally ☐ Reluctantly

Suck thumb, finger, pacifier, etc.? ☐Yes ☐No If yes, at what age was the habit discontinued? _____

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT:

Is the patient aware of a problem? ☐Yes ☐No

The patient's interest in having treatment is: ☐ Excited ☐ Willing if necessary ☐ Reluctant

BEHAVIOR ASSESSMENT:

Personality (check all that apply): ☐ Calm ☐ Nervous ☐ Quiet ☐ Shy ☐ Outgoing ☐ Uncooperative ☐ Cooperative ☐ Confident ☐ Afraid ☐ Emotional disturbance

Progress at school when compared to children of the same age: ☐ Behind ☐ Same level ☐ Advanced

GROWTH STATUS: Height: _____ Weight: _____

Females: Has the patient started her menstruation? ☐Yes ☐No If yes, at what age? _____

Males: Has the patient undergone voice changes? ☐Yes ☐No Facial hair growth? ☐Yes ☐No

☺ **Thank you for your help! We're excited to get to know you better….** ☺

Signature of the person completing this form:_____

Relationship to the patient:_____ Today's date:_____