



PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date
Patient's name (Last, First, Middle)
Address (Street, City, Zip)
Nickname, Birth date, Social Security #
School, Grade, Sports/Hobbies
Patient's email, Patient's Cell Phone
Parent or guardian name
Whom may we thank for referring you to our office?

RESPONSIBLE PARTY INFORMATION

Name (Last, First, Middle)
Residence (Street, City, Zip)
Mailing Address (Street, City, Zip)
How long at this address?, Home phone, Work phone
Cell/other phone, Email address
Previous Address (If less than 3 years)
Social Security #, Birth date, Relationship to Patient
Employer, Occupation, No. years employed
Spouse's Name, Relationship to Patient
Employer, Occupation, No. years employed
Social Security #, Birth date, Work Phone

DENTAL INSURANCE INFORMATION

Insured's Name, Insured's Social Security #
Insurance Company, Group No., Local No.
Insurance Co. Address, Phone No.
Do you have dual coverage? Yes, No, If yes:
Insured's Name, Insured's Social Security #
Insurance Company, Group No., Local No.
Insurance Co. Address, Phone No.

EMERGENCY INFORMATION

Name of nearest relative not living with you
Complete address (Street, City, Zip)
Phone

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____

Female Patients only (used to determine the amount of growth remaining):

Yes No Has menstruation started, and if so, month/year? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
Did your dentist refer you to our office? YES or NO (circle response)
What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
What is the patient's attitude toward receiving orthodontic treatment? _____
Height of parents? Mom _____ Dad _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Caggiano perform a complete orthodontic evaluation.

Signature: _____ Date: _____