Today's Date

PLEASE PRINT CLEARLY

Keesler Orthodontics
For Children and Adults

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Child Patient Information

PATIENT: Name (FIRST / MIDDLE INITIAL / LAST)		Nickname	Birthdate / AGE	Sex
Home Address	City	Zip	Home Phone	
School	City	Grade		
Sibling Name/Birthdate		Sibling Name/Birthdate		
Sibling Name/Birthdate		Sibling Name/Birthdate		
Other family members seen in our office		Referred by		
FATHER: Name				
Home Address	City	Zip	Home Phone	
Employer		Occupation		
Employer's Address	City	Zip	Work Phone	
MOTHER: Name				
Home Address	City	Zip	Home Phone	
Employer		Occupation		
Employer's Address	City	Zip	Work Phone	

Dental Insurance Information

PRIMARY INSURANCE: Insured Member		Social Security No.	Birthdate
Primary Insurance Company		Phone	
Address	City	State	Zip
Insured's Employer		Group No.	
SECONDARY INSURANCE: Insured Member		Social Security No.	Birthdate
Secondary Insurance Company		Phone	
Address	City	State	Zip
Insured's Employer		Group No.	
RESPONSIBLE PARTY INFORMATION: Name			
E-mail Address	Home Phone	Work Phone	
Address	City	State	Zip

I (we) accept responsibility for payment of all costs incurred with Keesler Orthodontics. I understand that, where appropriate, Credit Bureau reports may be obtained.

Signature of Parent/Guardian Date

Dental History

Patient's Dentist	City	Phone	
Primary Concern	Date of last cleaning		
1. Has there been previous orthodontic treatment?	☐ Yes ☐ No	If yes, by whom?	
2. Have there been primary (baby) teeth removed by a dentist?	☐ Yes ☐ No		
3. Is there or has there been a concern about periodontal (gum and bone) problems?	☐ Yes ☐ No		
4. Is there any UNUSUAL dental history?	☐ Yes ☐ No	If yes, please explain:	
5. Have any teeth been bumped or injured?	☐ Yes ☐ No	If yes, please explain:	
6. Does the patient have a tendency to gag easily?	☐ Yes ☐ No		
7. Do any speech problems exist?	☐ Yes ☐ No		

Continued on other side.

Dental History *Continued*

8. Has the patient HAD or PRESENTLY HAVE any of the following habits:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Thumb sucking	☐	☐	Lip biting	☐	☐	Grinding or clenching teeth	☐	☐	Other: _____
☐	☐	Finger sucking	☐	☐	Nail biting	☐	☐	Snoring			_____
☐	☐	Tongue thrusting	☐	☐	Mouth breathing	☐	☐	Smoking/Tobacco Chewing			_____

If yes, when did the habit stop?

9. Is the patient frightened or anxious about orthodontic treatment? ☐ Yes ☐ No

10. Is the patient concerned about the appearance of his/her teeth? ☐ Yes ☐ No

11. What aspect of orthodontic treatment are you most concerned about?

☐ Quality ☐ Cost ☐ Discomfort ☐ Length of Treatment

Medical History

Patient's Physician	City	Phone

1. Has the patient HAD or PRESENTLY HAVE any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Trouble	☐	☐	Tumors	☐	☐	HIV / AIDS	☐	☐	Emotional Problems
☐	☐	Heart Murmur	☐	☐	Convulsions	☐	☐	Bleeding Disorders	☐	☐	Headaches
☐	☐	Artificial Heart Valve/Pacemaker	☐	☐	Epilepsy	☐	☐	Glaucoma	☐	☐	Cleft Lip or Palate
☐	☐	Mitral Valve Prolapse	☐	☐	Cancer	☐	☐	Glandular Disorders	☐	☐	Jaw Clicking/Popping
☐	☐	High/Low Blood Pressure	☐	☐	Sleep Apnea	☐	☐	Genetic Disorders	☐	☐	Jaw Stiffness/Locking
☐	☐	Rheumatic Fever	☐	☐	Sleep Disorders	☐	☐	Kidney Disorders	☐	☐	Jaw Soreness
☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Breathing Disorders	☐	☐	Other: _____
☐	☐	Arthritis	☐	☐	Tuberculosis	☐	☐	Fainting/Dizziness			

2. Is the patient's general heath good at this time? ☐ Yes ☐ No

3. Is the patient under the care of a physician at this time? ☐ Yes ☐ No If yes, please explain:

4. Is the patient taking any medication(s) at this time? ☐ Yes ☐ No Name of medication(s):

5. Is the patient allergic to any medication(s)? ☐ Yes ☐ No Name of medication(s):

6. Does the patient have a latex allergy? ☐ Yes ☐ No

7. Does the patient have a metal allergy? ☐ Yes ☐ No

8. Has the patient had tonsils and/or adenoids removed? ☐ Yes ☐ No

9. Has the patient had a serious illness or been hospitalized? ☐ Yes ☐ No If yes, please explain:

10. Has the patient ever been advised by their physician to take an antibiotic prior to any dental procedures? ☐ Yes ☐ No

If yes, antibiotic name and method:

11. Has the patient shown signs of increased growth recently? ☐ Yes ☐ No

Present growth rate: ☐ Normal ☐ Rapid ☐ Slow ☐ None

12. Has the patient reached puberty? ☐ Yes ☐ No

13. Does the patient have a more than normal tendency toward having a cold, ear infection or sore throat? ☐ Yes ☐ No

14. Has the patient ever had a severe head or facial injury? ☐ Yes ☐ No If yes, please explain:

15. Has the patient ever taken any prescribed diet medication(s)? ☐ Yes ☐ No Name of medication(s):

16. Does the patient have any disease, condition, or problems not listed? ☐ Yes ☐ No

If yes, please explain:

Please use space below to provide any helpful information. Feel free to include any questions you may have:

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct.
THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED.
I grant authority to Keesler Orthodontics to perform all procedures and treatments in the patient's best interest.

I have been informed of Keesler Orthodontics Notice of Privacy Practices.

Member American Association of Orthodontists

Signature of Parent/Guardian Date