Preliminary Information

Date ____________

Patient's Name ________________________________ Nickname _____________ Sex __________

Birth date___________ Age in years_________ School _____________________ Grade__________

Home Address_____________________ City and Zip ____________________ Phone ____________

Father / Husband Name __________________ DOB _________Occupation ____________________

Social Security Number_____________________________Marital Status ______________________

Home Address_____________________ City and Zip ______________________ Phone __________

Business Name & Address ____ Phone __________

Mother / Wife Name ____________________ DOB __________Occupation ___________________

Social Security Number _____________ _____________ Marital Status _______________________

Home Address_____________________ City and Zip ______________________ Phone __________

Business Name & Address ____ Phone __________

Person Responsible for Account ____

Is patient covered by Orthodontic insurance? _____ If yes, please name _________________________

Family Physician ___________________________ Family Dentist ____________________________

Who may we thank for referring you to our office? ____

MEDICAL-DENTAL HISTORY

		yes	no
1	Is patient in good health?	❑	❑
2	Has patient ever been under the care of a physician or been hospitalized? If so state condition and duration ______________________________	❑	❑

3 Circle any of the following for which the patient has been treated

diabetes	tuberculosis	endocrine problems
pneumonia	anemia	prolonged bleeding
heart trouble	epilepsy	fainting or dizziness
rheumatic fever	asthma	nervous disorders
bone disorders	kidney involvement	liver involvement
blood disease	polio	

		yes	no
4	Has patient ever been tested for HIV?	❑	❑
5	Is patient presently taking drugs or medication?	❑	❑
6	Does patient have any ill effects from Novocaine, Penicillin, other antibiotics, or any other drugs?	❑	❑
7	Does patient have tendency to colds, sore throats or ear infection? (underline)	❑	❑
8	Have tonsils and/or adenoids been removed?	❑	❑
9	Has the patient reached puberty? Female Has she started her monthly periods? Age _________ Any other signs of pubertal development? ______________________________	❑	❑
	For males Has his voice changed? Age __________ Has he started to shave? Age __________ Any other signs of pubertal development? ______________________________	❑	❑

10 Height____________ Weight _____________ Father's Height _____________ Mother's Height ___________

11	Is there any information about patient's health that should be known, illness operations not indicated above? ______________________________	❑	❑

		Yes	No
12	Have there ever been any serious injuries to the face, mouth or teeth? ____________	☐	☐
13	Has the patient ever sucked the thumb or fingers? Until what age? ________	☐	☐
14	Has the patient ever had any habits such as pencil or lip biting, clicking jaw, tongue biting, grinding teeth, biting fingernails, leaning or sleeping on face? ____________	☐	☐
15	Does the patient generally breathe through the mouth instead of the nose? awake ___ asleep __ Any difficulty in chewing? Explain ____________	☐ ☐	☐ ☐
16	Is there a history of difficulty in properly swallowing, pronouncing certain words, and/or tongue thrusting?	☐	☐
17	Has patient had any pain in or near the ears?	☐	☐
18	Has the patient ever had bleeding or sore gums, "Trench Mouth", teeth sore to cold or sweets?	☐	☐
19	Does patient have any present dental complaints? Explain ____________	☐	☐
20	Has anyone else in the family had orthodontics?	☐	☐
21	Has the patient ever had any extra or missing teeth or had any teeth extracted? ____________	☐	☐
22	Does the patient play any instrument that touches the lips?	☐	☐
23	Has an orthodontist been consulted previously? ____________	☐	☐
24	What would you like to have orthodontic treatment accomplish? ____________ ____________		

____
Signature of parent or patient

Consent to the use of photographs

I hereby consent to the use of photographs taken by Dr de Lorimier for educational and scientific purpose I understand that their use will in no way discredit or embarrass me

____
Signature of parent or patient

General consent to orthodontic treatment

I hereby consent to the performance of orthodontic treatment by Charles R de Lorimier, D D S , M S The nature and purpose of the treatment to be rendered, the possible risks involved, and alternative methods of treatment have been fully explained to me and no guarantee or warranty has been made to me that the results will be to my complete satisfaction, although it is believed that such results will be satisfactory

____
Signature of parent or patient

Acknowledgment of consultation on risks, responsibilities, and treatment objectives

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Signature of parent or patient