Dr. Barry White – Orthodontist

Patient's Name ______________________ Prefers to be called ______________

Address ______________________ Apt. No. ______ City __________ Postal Code __________

Telephone No. ____________ Date of Birth ____________ School ______________________

Email Address: ______________________________________

Mother's Name ______________________ Business Number ____________ Ext __________

Father's Name ______________________ Business Number ____________ Ext __________

Dentist ______________ Physician ______________ Medical Specialist ______________

When was your last dental visit?__________What was done at that visit?______________________

How did you find out about our office? ______________________________________

	Yes	No	Unsure
Is there a history in your family of irregular/protruding teeth? ______________	[ ]	[ ]	[ ]
Is there a history in your family of congenitally missing teeth? ______________	[ ]	[ ]	[ ]
Has any other member of your family had orthodontic treatment?______________	[ ]	[ ]	[ ]
Is your child's orthodontic problem obvious to you? ______________	[ ]	[ ]	[ ]
Is your child self-conscious because of her/his teeth? ______________	[ ]	[ ]	[ ]
Has your child ever had a thumb/finger sucking habit?______________	[ ]	[ ]	[ ]
Has your child had any severe accidents involving her/his teeth, jaws, lips?__________	[ ]	[ ]	[ ]
Does your child have frequent sore throats? ______________	[ ]	[ ]	[ ]
Does your child take any medications? Herbal?______________			
Does your child have any allergies?______________	[ ]	[ ]	[ ]
If yes, please describe ______________			
Does your child often breathe through his/her mouth?______________	[ ]	[ ]	[ ]
Has your child had tonsils or adenoids removed? ______________	[ ]	[ ]	[ ]
Has your child had any teeth extracted for any reason?______________	[ ]	[ ]	[ ]
If your child had any teeth extracted, were space maintainers used to prevent space closure?_____	[ ]	[ ]	[ ]
Has your child had any previous orthodontic consultations or treatment?______________	[ ]	[ ]	[ ]
Does your child have any emotional concerns re: dental treatment?______________	[ ]	[ ]	[ ]
At what stage of development is your child currently in? Pre-puberty or Puberty			
Is your child in good general health?______________	[ ]	[ ]	[ ]
Has your child ever required antibiotic premedication before receiving dental treatment?________	[ ]	[ ]	[ ]
Is your child currently under the care of a physician for any reason?______________	[ ]	[ ]	[ ]

Please circle if your child presently has or ever has had any of the following conditions.

-Heart murmur	-Cancer	-Hepatitis	-Rheumatic/Scarlet fever
-Artificial heart valve	-Asthma	-HIV	-Epilepsy
-Any heart problem	-Diabetes	-Fainting	-Blood disorder
-Organ transplant	-Artificial joints (hip, knee, other)		-High Blood pressure

Are there any other conditions or diseases not listed above that your child has or has had? If so, what?__________

Signature of Parent/Guardian ______________________________ Date ______________