Christopher M. Feldman, DDS

FELDMAN ORTHODONTICS

ORTHODONTIC PATIENT INFORMATION

Welcome to our office:

The following information is requested to enable me to give your child the best consideration of his/her orthodontic problem during the initial examination. For me to thoroughly diagnose any condition, I must have accurate background and health information on which to base my decisions. This information, which is important for my records, is confidential. Thank You.

Patient's Name _____ Age_____ Date of Birth _____/_____/____ Sex _____
LAST FIRST M.I. NICKNAME

Home Address _____ Home Phone_____
STREET CITY ZIP

School _____Grade _____Patient's E-mail Address _____

Physician _____ Dentist _____Referred By_____

Father/Guardian _____ Home #_____ Work # _____Cell #_____

Add: (Same ❒) _____ How Long? _____Social Security # _____ Mar. Status _____

Employer _____ # Yrs. Employed _____ Occupation_____

Mother/Guardian _____ Home #_____ Work # _____Cell #_____

Add: (Same ❒) _____ How Long? _____Social Security # _____ Mar. Status _____

Employer _____ # Yrs. Employed _____ Occupation_____

Person(s) Responsible for Account _____ Insurance Carrier _____ Insured D.O.B. _____

Responsible Party's E-mail Address _____

Names and ages of other children in family? _____

Emergency Information

Name of Nearest Relative Not Living With You? _____ Relation to Pt._____

Address _____ Telephone_____

Medical History (Please Check Those That Apply)

❒ Attention Deficit Disorder ❒ Epilepsy ❒ Hepatitis ❒ Nasal / Sinus Problems

❒ Asthma ❒ Growth Problems ❒ HIV Positive ❒ Rheumatic Fever

❒ Blood Disorders ❒ Hearing Disorder ❒ Kidney Disease ❒ Speech Disorder

❒ Diabetes ❒ Heart Disease ❒ Mononucleosis ❒ Tuberculosis ❒ Other: (describe below)

Comments: _____

_____

Is antibiotic medication necessary before dental appointments due to a heart condition? ..... ❒ Yes ❒ No

Has the patient been under the care of a physician during the past two years, other than for routine examinations? ..... ❒ Yes ❒ No

If yes, why? _____

Present drugs or medications:_____

Does the patient have any emotional or psychological disturbances? ..... ❒ Yes ❒ No

If yes, briefly describe: _____

Has the patient experienced a sudden increase in height?..... ❒ Yes ❒ No

If the patient is a male, has his voice changed?..... ❒ Yes ❒ No

has he started to shave?..... ❒ Yes ❒ No

If the patient is female, has she started her monthly period?..... ❒ Yes ❒ No

How long ago? _____

Current height? _____Current weight? _____

Mother's height? _____ Father's height? _____

Is the patient adopted?..... ❒ Yes ❒ No

Respiratory History

Does the Patient:

1. Have allergies to: Seasonal grasses ❒ Yes ❒ No Foods ❒ Yes ❒ No Metals ❒ Yes ❒ No Latex ❒ Yes ❒ No
   Drugs ❒ Yes ❒ No Other: _____
   If Yes, please specify:_____
2. Breathe through mouth regularly?..... ❒ Usually ❒ Sometimes ❒ Seldom
3. Snore when sleeping?..... ❒ Yes ❒ No
4. Has the patient received medical treatment from an allergist or ear, nose, and throat specialist? ❒ Yes ❒ No
   If Yes, When? _____ By Whom? _____
   For What?_____
5. Have chewing or swallowing difficulty?..... ❒ Yes ❒ No

Dental History

Does the patient visit his/her dentist regularly (twice a year)? ❒ Yes ❒ No

Last visit to the dentist? _____ Teeth cleaned? ❒ Yes ❒ No

Has he/she gone through a preventive program with his/her dentist? ❒ Yes ❒ No

Daily toothbrushing frequency? 1 ❒ 2 ❒ 3 ❒ More ❒ Floss Daily? ❒ Yes ❒ No

Facial or dental injury due to accidents or blows to the mouth? ❒ Yes ❒ No

If Yes, Explain: _____

Congenitally missing, extra, or impacted teeth? ❒ Yes ❒ No

Has the patient had any teeth extracted due to decay or gum disease? ❒ Yes ❒ No

Has the patient ever been treated by a periodontist (Gum Specialist)? ❒ Yes ❒ No

If yes, by whom? _____ When _____

The following habits are of interest. List information as it pertains to patient:

Thumb sucking until age _____ Grinding / clenching of teeth ❒ Yes ❒ No

Finger sucking until age _____ Tongue thrusting ❒ Yes ❒ No

Lip-biting or sucking ❒ Yes ❒ No Other habits ❒ Yes ❒ No

Does the patient have frequent headaches? ❒ Yes ❒ No

How often? _____ In the morning? ❒ Yes ❒ No In the evening? ❒ Yes ❒ No

Other: _____

Location of headaches? _____

Has the patient ever experienced pain, clicking, or popping in his/her jaw joints? ❒ Yes ❒ No

Pain R ❒ L ❒ Clicking R ❒ L ❒ Popping R ❒ L ❒ Earaches R ❒ L ❒

Has his/her jaw ever locked open? ❒ Yes ❒ No Locked Closed? ❒ Yes ❒ No

Has the patient ever been treated for temporomandibular joint (TMJ) problems? ❒ Yes ❒ No

If yes, by whom? _____ When? _____

Has an orthodontist been consulted previously? ❒ Yes ❒ No

Has the patient had orthodontic treatment previously? ❒ Yes ❒ No

By whom? _____ When? _____

Has anyone in your family had orthodontic treatment? ❒ Yes ❒ No

Has there been any apprehension or unfavorable experience in a dental office? ❒ Yes ❒ No

How does the patient feel about braces? ❒ Enthused ❒ OK ❒ Resentful

Is there a family history of similar orthodontic problems? ❒ Yes ❒ No If yes, please describe _____

_____

Does the patient play a musical instrument with his/her mouth? ❒ Yes ❒ No

What type of student is the patient? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

What level of cooperation can we expect from the patient? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

What is the primary reason for seeking this orthodontic evaluation?

_____

What concerns do you have about braces, orthodontic treatment, etc.?

_____

_____

Are parents aware that some orthodontic appointments will infringe on school time? ❒ Yes ❒ No

Please Read, Sign and Date: I, the undersigned, verify the accuracy of the above information. If there are any changes in the future, I will inform this practice of these changes. I hereby authorize Christopher M Feldman DDS LLC to obtain any information that may be required for credit acceptance in connection with the financial arrangements for orthodontic treatment.

_____ _____

Signature of Patient/Responsible Party Date