Dunn Orthodontics

Thomas W. Dunn, D.D.S. CAGS

WELCOME TO OUR OFFICE

Patient Information (Child)

Nickname: _____Age: _____ Date of Birth: _____

Patient Name: _____ Sex: M { } F { } Social Security No._____-_____-_____

Residence Address: _____ City: _____ St: _____ Zip: _____

Day Phone ( ) _____-_____ Home Phone ( ) _____-_____ Family Status: M [] D [] W [] S []

School: _____ Grade: _____ Special Interests: _____

Father's Name: _____ Address: _____ Social Security No._____-_____-_____

Employer: _____ Employer Address: _____ Bus. Phone ( ) ____-_____

Mother's Name: _____ Address: _____ Social Security No._____-_____-_____

Employer: _____ Employer Address: _____ Bus. Phone ( ) ____-_____

Names and Ages of Other Children in Family: _____

Have Any Received Orthodontic Treatment? _____

Whom May We Thank For Referring You? _____

Patient's Dentist: _____ Patient's Physician: _____

E-mail Address to send appointment reminders: _____

Responsible Party Information

Name: _____ Relationship: _____ Social Security No._____-_____-_____

Address: _____ Day Phone ( ) _____-_____ Evening Phone ( ) _____-_____

Previous Address (if less than 3 years) _____ City: _____ St: _____ Zip: _____

Employer: _____ Employer Address: _____

Occupation: _____ Number of years Employed _____ Bus. Phone: _____-_____

Spouse's Name: _____ Address: _____ SS# _____-_____-_____

Employer: _____ Employer Address: _____ Bus. Phone ( ) _____-_____

Do You Have Insurance Which May Pay for Orthodontic Treatment? Yes { } No { }

Are you covered by Other Dental Insurance? Yes { } No { }

Medical History

Is Patient in Good Health? Yes { } No { } Does Patient Have any History of Major Illness? Yes { } No { }

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

- ☐ Diabetes
- ☐ Pneumonia
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Bone Disorders
- ☐ Hepatitis
- ☐ Pregnancy
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Epilepsy
- ☐ Asthma
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Blood Disease
- ☐ Endocrine Problems
- ☐ AIDS/ARC
- ☐ Prolonged Bleeding
- ☐ Bisphosphonate Tx
- ☐ Immune Diseases
- ☐ Fainting / Dizziness
- ☐ Nervous Disorders
- ☐ Liver Disease
- ☐ Stomach Disorder

Have Tonsils, Adenoids or Impacted Teeth Been Removed? _____ At What Age? _____

List Any Drugs or Medications Now Being Taken or Previously Taken and Give Reason: _____

Dental History

Have there been any injuries to the face, mouth, teeth or jaw? ……..…. Yes No

Has the patient ever noticed any clicking, popping, or chronic dislocation of the joints of the jaw? …….. Yes No

Has the patient ever seen a doctor for jaw, face, or head pain? …… Yes No

Does the patient have any speech problems? …… Yes No

Is the patient a Mouth Breather? ……While Awake?….Yes No …….While Asleep? Yes No

Has the patient been to a dentist in the last 12 months? ……Yes No

Has the patient ever had operations or injuries of the head or neck? ……Yes No

Has the patient ever received a severe blow on the teeth or jaws? ……Yes No

Does the patient constantly have sore or bleeding gums? …… Yes No

Have any of the patient's teeth been removed? …… Yes No

Does the patient brush his/her teeth in the morning? …… Yes No

…… After Lunch? … Yes No …….. After Dinner? …. Yes No ……..…. Before Retiring? Yes No

Does the patient have problems in chewing, talking, or swallowing? …… Yes No

Has the patient ever had a time when the jaw couldn't open or couldn't close? …….. Yes No

Did the patient ever suck fingers, thumb, lips, or tongue? …… Yes No

Does/did the patient bite his/her lips, tongue, fingernails, pencils, or other objects? …… Yes No

Does the patient grit, grind, or clench his/her teeth at night? …… Yes No

Does the patient play a musical instrument? ….. Yes No …… What Kind? _____

Is the patient concerned about the appearance of the teeth? ……..… Yes No

Is the patient aware of, or concerned about, his/her orthodontic problem? …… Yes No

Is the patient's attitude toward wearing orthodontic appliances of one of:

Eagerness? Yes No Willingness? Yes No Complacency? Yes No

Resignation? Yes No Antagonism? Yes No

Has any member of the family had orthodontic treatment? …… Yes No

Who first noticed the need for orthodontic treatment?

Self? Yes No Dentist? Yes No Other? Yes No

Does the patient have arthritis in any joint in the body? …… Yes No

Are you interested in having orthodontic treatment for appearance? ……Yes No

Have you been informed of any missing or extra permanent teeth? …… Yes No

Has an orthodontist been consulted previously? ……Yes No

In your own words, what is the problem? _____

Has the patient ever been under mental stress? …… Yes No

Has the patient ever been treated for "Nerves"? …… Yes No

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information: _____

_____

_____ _____

Signature Date