STONEGATE ORTHODONTICS

Welcome!

1st Visit Date____________________ PATIENT NAME:____
LAST FIRST M.I.

Male___ Female___ Age_____ Date of Birth ______________ School____________________ Grade_______

Home Address____City______________________ Zip_________

Home Phone #_____________________ Cell Phone #________________ Email Address_________________

Referred by________________________Patient's Dentist_______________________ Last visit______________

Patient's Physician____________________________________ Oral Surgeon___________________________

Father's Name_____________________________________ SS#_____________________

Occupation_________________________________ Employer______________________

Business Address____________________________ Business Phone_________________

Mother's Name_____________________________________ SS#_____________________

Occupation_________________________________ Employer______________________

Business Address____________________________ Business Phone_________________

If parents are separated or divorced, who has financial responsibility?_____________________

Phone #_________________ Address_____________________________ City______________ Zip__________

HEALTH HISTORY: Is the patient in good health? YES___ NO___ If no, please explain:

____

Does the patient have a history of major illness or injury? YES___ NO___ If yes, please describe:

____

Has the patient ever been treated for: Rheumatic Fever Hepatitis HIV Heart Problem Glaucoma

LIST ANY CURRENT DRUGS/MEDICATIONS:____

LIST ANY DRUG ALLERGIES OR SENSITIVITIES:____

Have the patient's tonsils or adenoids been removed? YES___ NO___ If so, when?____________________

Has the patient reached adolescent growth? YES___ NO___
GIRLS: If monthly cycle has started, when?__________
BOYS: If voice has changed, when?________________

Patient's height: ___ft ___in
Father's height: ___ft ___in
Mother's height: ___ft ___in

Names & Ages of Brothers & Sisters____

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH, OR TEETH? YES___ NO____ If yes, please explain:

____

Does the patient play any musical instruments? If yes, which one(s)?_____________________________________

Does the patient normally breathe through his/her (While awake): _______ Mouth or _______ Nose?
(While asleep): _______ Mouth or _______ Nose?

HAS THE PATIENT HAD A HISTORY OF SUCKING A THUMB/FINGER? NO____ YES____ Until what age?_________

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA TEETH?____________________________________

Does the patient have any history of gum disease?__________ Clicking, popping or jaw pain?________________

Have you previously consulted with an Orthodontist?____

PRIMARY REASON FOR CONSULTATION____

Has any member of your family ever been seen in this office? If yes, who?___________________________

Date_________________ Signature____________________________________