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Atlanta Orthodontic Specialists

WELCOME

To assist us in providing the most comprehensive care, please provide the following personal information and health history.

Thank you

PATIENT INFORMATION

Name _____ Nickname _____
First *Middle* *Last*

Gender _____ Age _____ Date of birth _____ School _____ Grade _____

Dentist _____ Physician _____

Referred by _____ Was child adopted? _____

PARENT INFORMATION

Name _____ Name _____

Address _____ Address _____
If different

Home phone _____ Home phone _____

Mobile phone _____ Mobile phone _____

e-mail _____ e-mail _____

Employed by _____ Employed by _____

Work phone _____ Work phone _____

What are your chief concerns regarding your child's orthodontic condition? (overbite, crowding, function, esthetics, etc.)

_____

Please describe your reasons for considering orthodontic treatment.

_____ Improved facial appearance
_____ Improved functional health
_____ Enhanced long-term dental health
Other _____

Please describe your child's attitude toward orthodontic treatment.

_____ Eager
_____ Complacent
_____ Antagonistic

Please complete other side →

MEDICAL HISTORY

Does your child have a history of any of the following? *Yes or no?*

_____ HIV

_____ Asthma

_____ Diabetes

_____ Blood disorder

_____ Epilepsy

_____ Hepatitis

_____ Heart problems

_____ Glaucoma

_____ Rheumatic fever

_____ Frequent headaches

_____ Tonsil or adenoid removal

_____ Allergies *(if yes, please list)*

_____

_____

Is your child?
Yes or no?

_____ In good health

_____ Under a physician's care?
If yes, for what condition?

_____

_____

_____

Please note any other factors the doctor should know about your child's health:

_____

_____

_____

_____

_____

DENTAL HISTORY

_____ Thumb or finger sucking

_____ Had primary teeth removed

_____ Had permanent teeth removed

_____ Injury to face or teeth

_____ Night time teeth grinding

_____ Clicking or pain when opening jaws

_____ Speech problems

Other

_____

_____

_____ Recent dental check-up?Date:

_____ Previous orthodontic evaluation?

Date: _____

By whom? _____

_____ Previous orthodontic treatment?

Date: _____

By whom? _____

AUTHORIZATION

Payment is appreciated at the time services are provided. We will be happy to assist with the preparation of insurance claim forms for your reimbursement.

In the future, please advise the doctor of any changes in your child's medical or dental health while under care in this office.

I have read Atlanta Orthodontic Specialists' Notice of Privacy Practices.

_____

Signature *Date*