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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? *Check when yes*

- ☐ 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?
Check when yes

- ☐ In good health
- ☐ Does your child require premedication for dental procedure?
- ☐ Under a physician's care? *If yes, for what condition* _____

_____

_____

Please list any medications and note anything 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*