CENTRAL MASSACHUSETTS ORTHODONTIC ASSOCIATES, PC

Patient Information Under 18   Please Print

Patient Name ______________________ Nickname _________________ Date ________________

Female/Male   Birthdate _____/_____/_______   Age _______   Email ________________________

Address _________________________________ School ______________________ Grade _______

____ Height ________________ Weight ___________

____ Home Phone (_____)_______________________

Zip Code

Whom may we thank for referring you to our office? ______________________________________

Please list your chief complaint/concern:____

____

Responsible Party Information

Parent Name ______________________________ Parent Name __________________________

Address __________________________________ Address ______________________________

____ _____________________________________

Home Phone (_____)______________________ Home Phone (_____)__________________

Occupation ______________________________ Occupation ___________________________

Employed By _____________________________ Employed By __________________________

Email ____________________________________ Email ________________________________

Cell Phone (_____)________________________ Cell Phone (_____)______________________

Where/Whom to call in case of Emergency ____

Custodial Parent (as applies) ____

Legal Guardian ____

Dental Insurance Information

Primary Insured's Name_____________________ Secondary Insured's Name__________________

Social Security Number _____________________ Social Security Number ____________________

DOB of Insured ____________________________ DOB of Insured ___________________________

Insurance Company__________________________ Insurance Company_______________________

Ins. Co. Phone (_____)______________________ Ins. Co. Phone (_____)____________________

Policy Number______________________________ Policy Number___________________________

Group Number ______________________________ Group Number ___________________________

Medical Information

Patient's Physician________________________________ Phone (_____)___________

Is patient in good health? Yes____ No____

History of major illness or conditions____

Patient requires antibiotic premedication for dental appointments. Yes____ No_____

Yes		No	DK/U*
	Allergies		
	Asthma, sinus problems, hay fever		
	Anemia, excessive bleeding or bruising		
	Any injuries to face, head or neck		
	Arthritis or joint problems		
	Birth defects or hereditary problems		
	Bone disorders, fractures or major injuries		
	Cancer, tumor, radiation or chemotherapy		
	Cardiovascular disease, heart defects		
	Chest pain, shortness of breath		
	Diabetes or low blood sugar		
	Emotional problems		
	Endocrine or thyroid problems		
	Epilepsy or convulsion		
	Fever blisters/herpes		
	Frequent ear or throat infections, colds		

Yes		No	DK/U*
	Frequent headaches or migraines		
	High or low blood pressure		
	History of osteoporosis		
	HIV - AIDS		
	Hypoglycemia		
	Immune system disorders		
	Kidney problems		
	Mental health disturbance or depression		
	Patient tires easily upon exertion		
	Rheumatic fever		
	Seizures, fainting, neurological problems		
	Polio, mononucleosis, TB, pneumonia		
	Sexually transmitted infections		
	Skin disorder (other than common acne)		
	Ulcers/GERD/Reflux		

***Don't know/understand**

Please list all present medications ____

____

____

Puberty onset (mensturation or voice changes)? Yes____ No____

Pregnant? Yes____ No____

Is patient adopted? Yes____ No____

Have tonsils or adenoids been removed? Yes____ No____

Cognitive or develpmental challenges? Yes____ No____

Please describe any other medical conditions patient may have, not listed above.

____

____

Dental Information

Name of General Dentist ____

Yes		No	DK/U*
	Has patient had a recent dental exam?		
	Does patient have regular cleanings?		
	Injuries to mouth or teeth?		
	Previous orthodontic treatment?		
	Has dentist removed primary (baby) teeth?		
	Has dentist removed permanent teeth?		
	Have wisdom teeth been extracted?		
	Any sensitive or sore teeth?		
	Bleeding gums, bad taste or mouth odor?		
	Jaw fractures, cysts or infections?		
	Has jaw ever locked open?		
	Has jaw ever locked closed?		
	Clicking in jaw joints?		
	Soreness in jaw or facial muscles?		
	Nail biting?		

Yes		No	DK/U*
	Difficulty eating or chewing?		
	Teeth grinding or clenching?		
	Thumb or finger sucking habits?		
	Frequent mouth sores or herpes sores?		
	Difficulty breathing through nose?		
	Is patient a mouth breather?		
	History of speech problems?		
	Has patient had any jaw surgery?		
	Any teeth irritating lips, cheeks or gums?		
	Frequent mouth sores or herpes sores?		
	High intake of sweets or sodas?		
	Tongue thrusting habits?		
	High intake of sweets or sodas?		
	Any diagnosis of gum disease?		
	Any traumatic past dental experience?		

***Don't know/understand**

School attending ____________________________ Grade ______________

List sports played____

List any instruments played____

Siblings____

Friends that are patients____

Patient's attitude toward orthodontics ____Eager ____Complacent ____ Not enthusiastic

We welcome your comments and suggestions. ____

____

____

Updates (Date & Init - for office use)____

Signature____ Date___________________________

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status including changes in medications and health history as well as demographic information.

Preferred Name ____ Acct# ______________________

Age at Initial Exam _________years________months DOB _______________________

Teeth Present

E D C B A A B C D E
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8
E D C B A A B C D E

Classification of Malocclusion ____

Overjet ______________ mm Overbite ______________ mm Openbite _______________

Crowding _______________________________________ Spacing ___________________________

Constriction Y N ____

______ ↓

Teeth With Wear

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Teeth in Crossbite

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Midlines On Off MX shifted _____________ MD shifted _____________

Opening Path ____

Curve-of-Spee Flat / Mild / Moderate / Two-Plane

Frenum ____

Mucogingival & Recession Findings

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Oral Cancer Screening ____

TMJ Palpation Right _________________________ Left ______________________________

TMJ Auscult. Right _________________________ Left _____________________________

Examining Dr. ________________________________ Date______________________________