RIO GRANDE ORTHODONTICS

PATIENT'S CLINICAL HISTORY/FAMILY INFORMATION

Name _____ Age _____ Sex ____ DOB _____
Last First MI

Address _____ Telephone # _____
Street City Zip

School _____ Grade _____ SS # of Patient _____

Medicaid Insurance (if applicable) _____ Number_____

Email (for appointment reminders) _____ Would you like text reminders _____

Father's Name _____ Father's SS # _____ DOB _____
Last First MI

Home Address _____ Telephone # _____
Street City Zip

Employer _____ Work Tel # _____
Name Street City Zip

Does Father have Orthodontic Insurance? Y / N Name of Insurance Company _____

Does Father have Medical Insurance? Y / N Name of Insurance Company _____

Mother's Name _____ Mother's SS # _____ DOB _____
Last First MI

Home Address _____ Telephone # _____
Street City Zip

Employer _____ Work Tel # _____
Name Street City Zip

Does Mother have Orthodontic Insurance? Y / N Name of Insurance Company _____

Does Mother have Medical Insurance? Y / N Name of Insurance Company _____

If the Responsible Party is someone other than the patient's parents, please give information: ☐ Not Applicable

Name _____ SS # _____ Relationship to Patient _____

Address _____ Telephone # _____

Does Responsible Party have Orthodontic Insurance? Y / N Name of Insurance Company _____

Does Responsible Party have Medical Insurance? Y / N Name of Insurance Company _____

Patient's Dentist _____ Patient's Physician _____

Whom May We Thank for Referring You to Our Office _____

Patient Special Interests & Hobbies _____

_____

Please Describe Why You Sought This Consultation _____

_____

MEDICAL HISTORY

Now or in the past, has your child had:

	YES	NO		YES	NO
Birth Defects	☐	☐	Face, Head, Neck Injuries	☐	☐
Heart Defects or Heart Murmur	☐	☐	Frequent Ear/Throat Infections	☐	☐
High or Low Blood Pressure	☐	☐	Seizures, Fainting, Epilepsy	☐	☐
Heart Attack/Stroke/Angina	☐	☐	Frequent Headaches or Migraines	☐	☐
Chest Pain/Shortness of Breath	☐	☐	History of Eating Disorder	☐	☐
Blood Disorders	☐	☐	ental Health Problems	☐	☐
Skin Disorders	☐	☐	Bone Disorders	☐	☐
Hepatitis or other liver problems	☐	☐	Arthritis (any type)	☐	☐
Diabetes or low sugar	☐	☐	Sleep Apnea	☐	☐
Ulcers	☐	☐	Vision, Hearing, Speech Problems	☐	☐
Herpes (any type)	☐	☐	Asthma, Sinus Problems, Hayfever	☐	☐
AIDS/HIV Positive	☐	☐	Immune System Problems	☐	☐
Cancer or Tumor	☐	☐	Endocrine or Thyroid Problems	☐	☐
Kidney Problems	☐	☐	History of Osteoporosis	☐	☐
Tuberculosis or Pneumonia	☐	☐	Tonsil or Adenoid Condition	☐	☐

Has your child had allergies or reactions to any of the following? (check all that apply): ☐) Known Allergies

☐ Local Anesthetics (Novacaine, Lidocaine, etc.) ☐ Latex ☐ Aspirin ☐ Penicillin ☐ Other

An☐ tics ☐ Metal ☐ welry, Nic☐ etc.) ☐ Acry☐ ☐ Plan☐ llens ☐ Animals

Foods Other Substances

Comments _____

Please list any other significant information about your medical history _____

_____

DENTAL HISTORY

Now or in the past, has your child had:

	YES	NO		YES	NO
Early or Late Erupting Teeth	☐	☐	Primary Teeth Extracted	☐	☐
Permanent Teeth Removed	☐	☐	Congenital Extra or Missing Teeth	☐	☐
Chipped or Injured Teeth	☐	☐	Sensitive or Sore Teeth	☐	☐
Lost or Broken Fillings	☐	☐	Jaw Fractures, Cysts, Infections	☐	☐
Root Canals or Pulpotomies	☐	☐	Periodontal (gum) Disease	☐	☐
Speech Problems/Speech Therapy	☐	☐	Mouth Breathing Habit/Snoring	☐	☐
Oral Habits (sucking thumb, etc.)	☐	☐	nding or Clenching	☐	☐
Locking in Jaw Joints	☐	☐	n Jaw/Face Muscles	☐	☐

Comments _____

Please list any other significant information about your dental history _____

_____

RELEASE AND WAIVER

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company

Parent/Guardian Signature #1_____ Date _____

Parent/Guardian Signature #2_____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health. I hereby consent to the taking of x-rays, photographs and other necessary records before, during and after treatment.

Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____