PAGE • CONDICT ORTHODONTICS

ROBERT M. PAGE, D.D.S., M.S.
CHAREE CAMPBELL CONDICT, D.D.S., M.S.D.
Practice limited to Orthodontics

Today's Date _____

Patient's Name _____ _____ _____ _____ ____ _____ _____
First Middle Last I prefer to be called Sex Date of Birth Age

Patient's address _____ _____ _____
Street City Zip Code Home Phone Cell Phone

Father's Name _____ Mother's Name _____

Father's employer _____ Phone _____ Mother's employer _____ Phone _____

Responsible Party Name _____ Responsible Party Address _____

Family Dentist _____ Address _____

Who suggested your child might need orthodontic treatment? _____

How did you hear about our office? Internet? __ Insurance?__ Referral? __ If so, whom? _____ Other?__ (Please check one)

Attends school at _____ Number of brothers/sisters ____ Ages _____

Other family members treated here: _____

Hobbies _____ Sports _____ Other interests _____

Would you like to receive text messages for appointment reminders? If so, please list up to 3 cell phone numbers to receive text messages:

_____ E-Mail _____

INSURANCE

Is there insurance covering orthodontics?_____ Name of insurance carrier _____

Phone # and address of insurance carrier_____

Employee Name_____ Employer _____ Group # _____

Employee ID #_____ Employee Date of Birth _____

MEDICAL HISTORY

Patient size: _____ Average _____ Large _____ Small Patient's Height _____ Weight _____ Onset of puberty ____ Yes ____ No

Father's Height _____ Mother's Height _____ Natural Child _____ Adopted _____

Patient most resembles? _____ Mother _____ Father _____ Other

Present state of health: _____ Excellent _____ Good _____ Fair _____ Poor

Currently under physician's care? _____ Yes _____ No Why? _____

Is the patient under psychological guidance? _____ Yes _____ No

Currently taking medication? _____ Yes _____ No What? _____

Is there any history of:

_____ Speech problems
_____ Facial injuries
_____ Hearing problems
_____ Bone fractures/major accidents
_____ Frequent headaches
_____ Bleeding disorders
_____ Facial operations
_____ Asthma, sinus trouble, hay fever
_____ Rheumatoid or arthritic conditions
_____ Frequent colds or sore throats
_____ Birth defects
_____ Vision impairment
_____ Tonsil or Adenoid conditions
_____ Cancer, tumor, radiation, or chemotherapy
_____ Cardiovascular problem (heart murmur, rheumatic heart disease, congenital heart efects, etc.)

Please explain any of the above positive responses: _____

Allergies or reactions to the following

____ Local anesthetics (novacaine or lidocaine)
____ Penicillin or other antibiotics
____ Metals (jewelry, clothing snaps)
_____ Aspirin
_____ Latex (gloves, balloons)
_____ Acrylic
_____ Ibuprofen (Advil, Motrin)
_____ Vinyl
_____ Other substances (specify)

Other Allergies? – Please list: _____

Serious illnesses? Operations? _____

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DENTAL HISTORY

Has patient had: _____Regular dental check-ups _____ X-rays _____ Impressions ____ Extractions

Eruption of teeth: _____Early _____ Average _____ Late _____ Markedly delayed

Oral hygiene habits: _____ Good _____ Poor Intake of sweets: _____ High _____Moderate _____ Low

Indicate habits, past or present, relating to the mouth or face:

_____ Thumb or finger sucking - Age?____ _____ Mouth breathing _____ Lip Biting

_____ Tongue thrust/swallowing problems _____ Chewing habits _____ Nail biting

_____ Sleeping habits _____ Tooth grinding/clenching _____ Speech problems

DENTAL and ORTHODONTIC INFORMATION

Now or in the past, has the patient had:

_____ Trouble losing baby teeth _____ Permanent or "extra" teeth removed ____ Extra or missing teeth

_____ Injury to baby or permanent teeth _____ Teeth sensitive to hot/cold or toothache ____ Jaw fractures/cysts/infections

_____ Root canals or "dead" teeth _____ Periodontal "gum" problems ____ Ringing in ears

_____ Pain/soreness in muscles of face _____ Difficulty chewing or opening jaw ____ Jaw pain

_____ Jaw clicking/popping/locking _____ Teeth irritating cheek, lip, tongue, or palate ____ Injury to face or jaw

_____ Frequent cold sores _____ Concerned about spaced, crooked, or protruding teeth

_____ Ever had a prior orthodontic exam or treatment _____ Aware or concerned about an under or over-developed jaw

_____ Any relative with similar tooth or jaw relationships

Previous orthodontic treatment – Patient? _____ Yes ____ No Others in family? ____Yes ____ No

If so, with what result for patient? ____Excellent ____Good ____ Poor For others in family? _____ Excellent _____Good _____ Poor

What do you consider to be the main benefits of orthodontic correction?

_____Cosmetic _____Functional _____ Psychological/ Emotional Other _____

Is patient self-conscious of his/her teeth? _____ Yes _____ No

What is the patient's attitude toward treatment? _____Enthusiastic _____ Indifferent _____ Resentful

Expected patient cooperation: _____Excellent _____ Good _____ Fair _____ Poor

What is your primary concern?

_____

Is there any hereditary background which might contribute to this orthodontic problem?

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his /her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed _____ Date _____
(Parent or Guardian)

Signed _____ Date _____
(Witness)

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