smilesbypocock

Certified Specialist in Orthodontics

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Patient Name:________________________________ Sex: M F Age:______ Birthday: ________________________

Responsible Party: (Child only) Mom:_________________________ Dad:______________________________________

Anyone else you would like Dr. Pocock to see? Y/N If yes please list:____

Address: ____________________________ City:________________________ Postal Code:______________________

Home Phone:__________________ Cell Phones: Mom:____________________ Dad:___________________________

Do you have insurance for orthodontics? YES NO if yes, what is the percentage?______% Lifetime Max?________

Name of Dentist:_____________________________ Name of referral:_______________________________________

Name of other health care providers: (MD, any specialists):____

Email Address:____

What is your primary concern?____

What is the patient's genetic background/ethnic origin? Mom's family:_________________ Dad's family:________________

MEDICAL HISTORY **Please circle YES or NO for the following questions:**

Is Patient in good general health: Y N Is Patient currently under the care of a physician: Y N Has patient reached puberty? Y N

Any prolonged bleeding Y N Nervous disorders Y N Diabetes Y N Allergies Y N Bone Disorders Y N HIV Y N TB Y N

Fainting/Dizziness Y N Gland problems Y N Blood problems Y N Epilepsy Y N Infections Y N Hepatitis Y N Aids Y N

Immunity problem Y N Pneumonia Y N Anemia Y N Heart trouble Y N Kidney problem Y N Arthritis Y N

Car accident Y N Rheumatic fever Y N Liver problem Y N Major trauma Y N Asthma Y N

Use the space below to provide additional information about any YES questions:

DENTAL HISTORY **Please circle YES or NO for the following questions:**

Has patient ever had any type of orthodontic treatment including removable appliances? Y N ______________________________

Injury to face, chin, mouth, neck, teeth Y N if yes,list:

____

Previous or ongoing thumb, finger or other habit? Y N If yes, how long?_______________________________________

Has patient ever had speech therapy? Y N Any Speech problems? Y N if yes, which sounds:______________________________

Is the patient a mouth breather? Night Y N Day Y N Have tonsils been removed? Y N Adenoids removed? Y N

Have you been informed the patient has any missing teeth? Y/N Does patient have any extra teeth? Y N

Have you or any other family members had orthodontic treatment? Y N

List:____

Does patient(child only) have siblings? Y N Please list names/ages:____

Does patient have any difficulty or experience pain when opening the mouth, chewing, yawning? Y N if yes, please list below:

____

Does patient have any muscle or jaw joint problems or been treated for jaw joint disorders? Y N if yes, please list below:

____

Does the jaw ever get locked or stuck open or closed? Y N ________________ Does patient get frequent headaches? Y/N

Patient or responsible party signature:____