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Member American Association of Orthodontists

ROSS Orthodontics

- Please Print -

DATE _____

DATE OF BIRTH _____

Patient's Name _____ Age _____ Sex: Male ☐ Female ☐
First Middle Last

Name Patient Prefers to be Called _____ Telephone Number _____

Home Address _____ Zip Code _____

How long at this address? _____ Previous address if less than 3 years _____

School _____ Grade _____ Physician _____

Patient's Dentist _____ Last Visit to Dentist _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Father's Name _____ Occupation _____

Employed by _____ Business Telephone _____

Mother's Name _____ Occupation _____

Employed by _____ Business Telephone _____

Name and Address of Person Responsible for Account _____

Relationship to Patient _____

Marital Status: Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed ☐

Names and Ages of Other Children in Family _____

Do you have dental insurance that covers orthodontic treatment? ☐ Yes ☐ No Name of company _____

Has the patient been under the care of a physician for a specific problem within the last 2 years? ☐ Yes ☐ No Illness _____

List any medicines your child is currently taking _____

List any drug sensitivities _____

Is there a history of serious illness, accident or operation? _____

If so, list _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

☐ Contact Lenses	☐ High Blood Pressure	☐ Allergies or Asthma	☐ Speech Problems
☐ Glaucoma	☐ Head or Facial Injury	☐ Rheumatic Fever	☐ Emotional Problems
☐ Heart Trouble	☐ Tonsils/Adenoids removed	☐ Diabetes	☐ Endocrine Problems
☐ Kidney Disease	☐ Hearing Disorder	☐ Bleeding Problems	☐ Nervous Disorders
☐ Hepatitis/Liver Disease		☐ Epilepsy	☐ Adopted

Has the patient reached puberty? _____

Girls: Has she started menstruation? ☐ Yes ☐ No If yes, Month/Year _____

Boys: Has his voice changed: ☐ Yes ☐ No

Height _____ Weight _____

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth? _____ ☐ Yes ☐ No

Has the patient ever sucked a thumb or fingers? _____ ☐ Yes ☐ No

Until what age? _____ Is the patient a mouth breather? _____ While awake _____ ☐ Yes ☐ No

Are lips apart often? _____ While asleep _____ ☐ Yes ☐ No

Has an orthodontist been consulted previously? _____ ☐ Yes ☐ No

Has the patient had any previous orthodontic treatment? _____ ☐ Yes ☐ No

If so, by whom? _____

Have you been informed of any missing or extra permanent teeth? _____ ☐ Yes ☐ No

Please list any family members previously treated here. _____

What part of your child's orthodontic problem concerns you most? _____

List patient's musical preferences, sports, hobbies and interests _____

What are the patient's attitudes toward: Brushing _____ Dentistry _____ Orthodontics _____

Additional information that you feel would make your child's experience with us more enjoyable. _____

THANK YOU!

_____
Signature of Parent or Guardian