

# Todd G. Engstrom DDS, MS

Pediatric and Adult Orthodontics

Diplomate of the American Board of Orthodontics

**BRACES**  
~~**BRACES**~~  
**BRACES**

Date Today \_\_\_\_\_

## PERSONAL INFORMATION

Patient's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Home Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Name of Family Physician: \_\_\_\_\_

Whom can we thank for referring you to this office? \_\_\_\_\_

If patient is already in orthodontic treatment, former orthodontist's name and address: \_\_\_\_\_

### Information For Patients Who Are MINORS:

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Interests: \_\_\_\_\_

What is the child's attitude toward: Brushing \_\_\_\_\_ Dentistry \_\_\_\_\_ Orthodontics \_\_\_\_\_

Parents' Marital Status:  Married  Separated  Widowed  Divorced If divorced, who has custody of child? \_\_\_\_\_

### Responsible Party Information

Email Address: \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle Marital Status

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address? \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
Last First Middle Relationship to Patient

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

### MEDICAL HISTORY

Is the patient in good health?  Yes  No Reason: \_\_\_\_\_

Any major or unusual illnesses?  Yes  No Explain: \_\_\_\_\_

Currently under physician's care?  Yes  No Reason: \_\_\_\_\_

Currently taking medication?  Yes  No List: \_\_\_\_\_

Allergies  Yes  No List: \_\_\_\_\_

Drug sensitivity  Yes  No List: \_\_\_\_\_

**Please Check if Patient Has or Had Any of the Following:**

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds or Flu
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems
<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis/Adenitis
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils Removed: Age: _____
<input type="checkbox"/>	<input type="checkbox"/>	AIDS antibody positive	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Adenoids Removed: Age: _____
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Mouthbreathing: _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease				<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems

**Growth Information for Patients Under 16 Years of Age**

Father's Height: \_\_\_\_\_ Mother's Height: \_\_\_\_\_ Adopted?  Yes  No

Patient Resembles:  Neither Parent  Mother  Father

Girls: Has she started menstruation?  No  Yes When? \_\_\_\_\_

Boys: Has his voice changed?  No  Yes When? \_\_\_\_\_

Names and Ages of Patient's Brothers and Sisters? \_\_\_\_\_

Have any had Orthodontic Treatment?  No  Yes When? \_\_\_\_\_

**DENTAL HISTORY**

Name and address of patient's general dentist? \_\_\_\_\_

When did patient last see the dentist? \_\_\_\_\_

YES NO

Has the patient had any severe head or face injuries? Explain: \_\_\_\_\_

Has the patient had a history of thumb sucking or finger sucking? Stopped? \_\_\_\_\_

Does the patient play any musical (wind) instruments? What? \_\_\_\_\_

Has the patient consulted an orthodontist previously? \_\_\_\_\_

Has the patient had any previous orthodontic treatment? \_\_\_\_\_

**Please Respond to the Following:**

YES NO

1. Do you have difficulty opening your mouth?

2. Do you hear noises from the jaw joints?

3. Does your jaw get "stuck," "locked," or "go out"?

4. Do you have pain in or about the ears, temples, or cheeks?

5. Do you have pain with chewing or yawning?

6. Does your bite feel uncomfortable or unusual?

7. Do you have frequent headaches?

YES NO

8. Have you had a recent injury to your head or neck?

9. Do you have arthritis?

10. Do you have problems chewing, talking, or using your jaws?

11. Do you clench or grind your teeth?

12. Have you previously been treated for a jaw joint (TMJ) problem? If so, when? \_\_\_\_\_

Is there any other information that may be helpful? \_\_\_\_\_

Why are you seeking orthodontic consultation? \_\_\_\_\_

Person responsible for payment of account? \_\_\_\_\_

Do you have orthodontic insurance? \_\_\_\_\_ Insurance company \_\_\_\_\_

Do you have medical insurance? \_\_\_\_\_ Insurance company \_\_\_\_\_

**I have read and received a copy of Notice of Privacy Practices \_\_\_\_\_ (PLEASE INITIAL)**

This office will assist you in filing your insurance. Services rendered are charged to the patient, not the insurance company, and patients are expected to take care of their fees as services are rendered.

In separation/divorce situations, the individual who initiates services with us is held financially responsible. We do not bill another person or an estranged spouse unless that individual informs us in writing of his or her willingness to pay for services.

I understand that where appropriate, credit bureau reports may be obtained.

THANK YOU!

Signed: \_\_\_\_\_ Date: \_\_\_\_\_