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 _____ Relationship to Patient _____
Last First Middle

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: _____

Continued on Back

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

YES	NO		YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Frequent Colds or Flu
☐	☐	Blood Disease	☐	☐	Tuberculosis	☐	☐	Hearing Problems
☐	☐	Prolonged Bleeding	☐	☐	Diabetes	☐	☐	Tonsilitis/Adenitis
☐	☐	Hepatitis	☐	☐	Endocrine Problems	☐	☐	Tonsils Removed: Age: _____
☐	☐	AIDS antibody positive	☐	☐	Bone Disorders	☐	☐	Adenoids Removed: Age: _____
☐	☐	Jaundice	☐	☐	Epilepsy	☐	☐	Asthma
☐	☐	Rheumatic Fever	☐	☐	Herpes	☐	☐	Mouthbreathing: _____
☐	☐	Kidney Disease				☐	☐	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?
☐	☐	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: _____