

Stephen W. Bradford, D.M.D., P.A.

Practice Limited to Orthodontics and Dentofacial Orthopedics
Member AMERICAN ASSOCIATION OF ORTHODONTISTS

Patient History and Acquaintance Information (Child)

Please Complete All Blanks

Date: _____ Family Dentist: _____ Referred by: _____

Name: _____ Nick name: _____

Age: _____ Birth date: __/__/____ Patients Sex: **M/F**

School: _____ Grade: _____ **E-mail:** _____

What type of student is the patient? ___Excellent ___Good ___Average

Hobbies: _____

Name and ages of other children in the family: _____

Patient's height: _____ Patient's weight: _____ Increase in past year: Height ___ Weight ___

Father's height: _____ Mother's height: _____ Patient resembles: Mother ___ Father ___ Neither ___

Growth and Development | Girls: Has menstruation begun? ___Yes ___No When? _____

Boys: Has voice changed? ___Yes ___No When? _____

Dental and Medical History

Has an Orthodontist been consulted previously? ___Yes ___No Dr: _____ Date: _____

Does the patient want teeth straightened? ___Yes ___No

Is the patient aware of any orthodontic problem? ___Yes ___No

Date of last dental checkup: _____ Were the teeth cleaned? ___Yes ___No

How many times per day does the patient **brush** their teeth? ___0 ___1 ___2 ___3 **floss?** ___0 ___1 ___2

Check Yes or No for which the patient has been diagnosed or treated. If Yes, please specify.

- | | | |
|---|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No Speech Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis/Adenitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Head/Face Injuries |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsils Removed | <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Injuries |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Risk Group/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No Adenoids Removed | <input type="checkbox"/> Yes <input type="checkbox"/> N Thumb/Finger Habit |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Difficult Oral Surgery |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Mouthbreathing | <input type="checkbox"/> Yes <input type="checkbox"/> No Clench/Grind Teeth |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No Missing/Extra Teeth |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Drug Sensitivity | <input type="checkbox"/> Yes <input type="checkbox"/> No Clicks/Pops of Jaw Joint |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Under Physicians Care | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Head/Ear Aches |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Endocrine Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Systemic Medications | <input type="checkbox"/> Yes <input type="checkbox"/> No Need to Premedicate |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Unusual Illnesses | <input type="checkbox"/> Yes <input type="checkbox"/> No Any Current Medications |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No In Good Health | <input type="checkbox"/> Yes <input type="checkbox"/> No Any Other Concerns |

Specific Notes: _____

Any Known Allergies: _____

Patients Family Physician: _____ Phone: _____ Date of last visit: _____

Would you consider patient's health to be: ___Excellent ___Good ___Fair ___Poor?

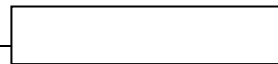
Person(s) to be Notified in Case of Emergency: _____ **Phone:** _____

I hereby certify that I have reviewed the above health history and that it is accurate to my knowledge at this time. If there are any future changes in this information, I will inform Dr. Bradford and staff of these changes. This information, important for our records and your health is confidential.

Signature of Responsible Party: _____ **Date:** _____

Updates: ____/____/____

Patient Information



Patient's name _____
 Address: _____
 Home Phone: _____ Cellular Phone/Beeper: _____
 Birthdate: __/__/____ Sex: _____
 Social Security #: _____ E mail address: _____
 If patient is a minor, give parent's or guardian's name: _____
 Whom may we thank for referring you to our office?: _____
 General Dentist: _____
 Family member in or out of orthodontic treatment: _____

Responsible Party Information

Name: _____
 Mailing Address: _____
 How long at this address: _____ Home Phone: _____
 Previous Address (if less than 3 years) _____ How long: _____

Father's Name: _____ **Marital Status:** _____ (If spouse is other than mother, fill out spouse line)
Soc. Sec. #: _____ **Dr. License #:** _____ **DOB:** _____
Employer: _____ **Occupation:** _____ **# of years employed:** _____ **Work Phone:** _____
Employer Address: _____
Spouse: _____ **Soc. Sec. #:** _____ **Dr. License #:** _____ **DOB:** _____
Mother's Name: _____ **Marital Status:** _____ (If spouse is other than father, fill out spouse line)
Employer: _____ **Occupation:** _____ **# of years employed:** _____ **Work Phone:** _____
Soc. Sec. #: _____ **Dr. License #:** _____ **DOB:** _____
Employer Address: _____
Spouse: _____ **Soc. Sec. #:** _____ **Dr. License #:** _____ **DOB:** _____

Insurance Information

Insured's Name: _____ **Insured's Social Security #:** _____
Insurance Company: _____ **Group#:** _____ **Local #:** _____
Insurance Company Address: _____ **Phone#:** _____
 Do you have dual coverage? Yes No If yes, please complete the information below.
Insured's Name: _____ **Insured's Social Security #:** _____
Insurance Company: _____ **Group#:** _____ **Local #:** _____
Insurance Company Address: _____ **Phone#:** _____

I, _____, give Dr. Bradford's office permission to check my credit history through the Credit Bureau. I understand that by doing so there will be a notation on my record of the inquiry. This inquiry is necessary to obtain financing through Dr. Bradford's office for orthodontic care of the above named patient. _____

Signature (Parents if minor): _____ **Date:** _____

Previous Orthodontist Information

If transferred, name of previous orthodontist: _____ **Phone:** _____
Complete Address: _____