NEIL M. WALLE, DDS, MS
Specialist in Orthodontics
MEDICAL AND DENTAL INFORMATION
CHILD PATIENT

Date _____/_____/_____ PATIENT INFORMATION

Patient Name_____ Nickname _____ Sex _____M_____F
Last First MI

Date of Birth_____/_____/_____ Age_____ If patient is a minor, give parent's or guardian's name _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First MI

Residence _____ Own _____ Rent _____
Street City State Zip

Mailing Address _____
Street City State Zip

How Long at this Address _____ Primary Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ - ____ - _____ Birthdate ____ / _____ / _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ - _____ - _____ Birthdate _____/_____/_____ Work Phone _____

PATIENT MEDICAL HISTORY

The patient's Medical and Dental History information is very important. This information bears directly on the outcome of treatment and is also important in helping to avoid complications. Thank you for taking the time to answer these questions.

1. Is the patient in good health? …… Yes No
2. Has there been any change in the patient's general health within the past year? …… Yes No
   If yes, please explain _____
3. Is the patient now under the care of a physician? …… Yes No
   If yes, what is the condition being treated? _____
4. The name of the patient's physician _____
5. Is the patient taking any medicine(s) including non-prescription medicine? ……. Yes No
   If yes, what medicine(s) are being taken? _____
6. Has the patient had any serious illness, operation or been hospitalized in the past 5 years? ..... ……. Yes No
7. Does your child have any learning or behavior difficulties? ……. Yes No
   If yes for 6. or 7. above, please explain _____

CIRCLE ANY OF THE FOLLOWING WHICH YOUR CHILD HAS HAD OR NOW HAS:

AIDS	BLOOD DISORDERS	HEART SURGERY	LIVER DISEASE	STROKE
ABNORMAL BLEEDING	CANCER OR TUMOR	HEART DISEASE	PSYCHIATRIC TREATMENT	THYROID PROBLEMS
ANEMIA	DIABETES	HEPATITIS	RECENT WEIGHT LOSS/GAIN	TUBERCULOSIS
ANGINA	EPILEPSY	HIGH BLOOD PRESSURE	RHEUMATIC FEVER	ULCERS
ARTIFICIAL HEART VALVE	GLAUCOMA	HIV POSITIVE	SEIZURES	VENEREAL DISEASE
ARTIFICIAL JOINTS	HEART MURMUR	KIDNEY DISEASE	SINUS TROUBLE	NONE OF THE ABOVE

8. Does the patient have any disease, condition, or problem not listed above that you think I should know about?
   If so, please explain _____
9. List any allergies that the patient has _____

WOMEN

10. Is the patient pregnant? …… Yes No
11. Is the patient taking hormones/birth control pills …….. Yes No

The demographic and medical information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s) in the patient's health and of recent visits to the physician/dentist at my next visit. I understand that the information contained in this form may be used for billing purposes that may also be used for treatment planning with other health providers. Payments are due on a monthly basis. There will be a $30 service charge on all returned checks and a monthly service charge of $15 on all past due accounts. I understand that, when appropriate, credit bureau reports may be obtained.

Parent/Guardian Signature _____Date _____/_____/_____

DENTAL HISTORY

1. Name of General Dentist _____
2. When was the patient's last dental visit? _____ Reason for visit? _____
3. How frequently does the patient visit his or her dentist? _____ Months
4. Does the patient have any dental problems now? …… Yes No
   If yes, please explain _____
5. I would describe the patient's temperament as: _____
6. The patient's interests, hobbies or sports interests are: _____
7. Has the patient reached puberty? ……. Yes No
8. Are you pleased with the way the patient's teeth look? …….. Yes No
9. Is the patient unhappy with his or her smile? …….. Yes No
10. Has the patient ever had an injury to the head, face, or neck? …… Yes No
11. Has the patient ever had teeth removed? ……. Yes No
12. Is the patient a mouth breather? …….. Yes No
13. Has the patient ever had a finger or thumb habit? …….. Yes No
14. Are the patient's teeth sensitive to cold, hot or certain foods? …… Yes No
15. Would the patient mind wearing braces? ……. Yes No
    If yes, please explain _____
16. What are the patient's main reasons for seeking orthodontic treatment? _____

ORTHODONTIC INFORMATION

1. Has the patient ever had an orthodontic examination, evaluation, conference or consultation? ….. Yes No
2. Has the patient ever had orthodontic records, such as x-rays, study models or photographs? ……. Yes No
3. Has the patient ever had orthodontic treatment (braces)? …….. Yes No

PERIODONTIAL (GUM) INFORMATION

1. Do you feel the patient's gums are healthy? ……. Yes No
   If no, please explain _____
2. Do the patient's gums bleed when brushing? ……. Yes No
3. Have you or the patient ever been told that he/she has gum disease? …… Yes No
4. Will the patient follow instructions regarding good oral hygiene? …… Yes No

HEAD, NECK, TMJ (JAW JOINT) INFORMATION

1. Do you feel the patient's jaw joint is healthy? …… Yes No
   If no, please explain _____
2. Does the patient's jaw joint(s) click, crack, pop, grate or make any other sound(s)? …….. Yes No
3. Does the patient grind and/or clench his/her teeth? ……. Yes No
4. Has the patient ever had or have had jaw soreness, jaw pain, muscle soreness (jaw area) and/or neck soreness? …….. Yes No
5. Has the patient's jaw ever "locked" open or closed? …….. Yes No
6. Has the patient ever been told that he or she has TMJ or "jaw joint" problems? …… Yes No
   If yes, when and by whom? _____

The dental information provided is complete and correct to the best of my knowledge. I agree to inform this office of any changes in the patient's dental health and of recent visits to the patient's dentist at the next visit.

Parent/Guardian: _____ Date: _____

Medical/Dental History Update:

Date	Comments:	Signature of Parent/Guardian
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____