

Pediatric Dentistry
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Pediatric Dentistry of Central Florida
BISHOP • BERTOT

Orthodontics
John R. Smith, D.D.S., M.S.D.

Date: _____

Orthodontic Patient Information

Patient's Name _____
Last First Middle Nickname _____
 Address _____ Gender _____ Age _____
 City _____ State _____ Zip _____
 Home Phone _____ Fax _____ Birthdate _____ Social Security # _____
 E-Mail Address _____
 School/Employer _____ Grade _____
 How did you hear about our office? _____
 Siblings/Children Yes/No Name/Age _____ Name/Age _____ Name/Age _____

Responsible Party Information

Name _____
Last First Middle Social Security # _____
 Residence _____ How long at this address? _____
 Mailing Address _____
 Own _____ Rent _____ Home Phone _____ Fax _____ Cell Phone _____
 Previous Address (if less than 3 years) _____
 Birthdate _____ Relationship to patient _____ Marital Status _____
 Employer _____ Occupation _____ No. Years Employed _____
 Employer Address _____ Work Phone _____ Fax _____
 Spouse's Name _____
Last First Middle Birthdate _____
 Spouse's Employer _____ Spouse's Social Security # _____
 No. Years Employed _____ Occupation _____ Phone: Work _____ Cell _____

Orthodontic Insurance Information

Primary Insured's Name _____ Insured's Social Security # _____
 Primary Insured's Address _____
 Insured's Employer _____
 Insured's Employer Address _____ Phone _____
 Insurance Company _____ Group No. _____ Local No. _____
 Insurance Company Address _____ Phone _____ Fax _____
 Do you have dual coverage? Yes No If yes:
 Secondary Insured's Name _____ Insured's Social Security # _____
 Insured's Address _____
 Insured's Employer _____
 Insured's Employer Address _____ Phone _____
 Insurance Company _____ Group No. _____ Local No. _____
 Insurance Company Address _____ Phone _____ Fax _____

Emergency Information

Name of nearest relative not living with you _____ Phone _____ Relationship _____
 Address _____

Medical History

Physician _____ Date of last visit _____

Address _____ Phone _____ Fax _____

Please circle Yes or No (if Yes, please fill in details).

YES NO Are you taking any medication? _____

YES NO Are you allergic to any medication? _____

YES NO Do you have a history of major illness? _____

YES NO Have you had any major operations? _____

YES NO Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have.

AIDS	Diabetes	Hepatitis	Nervous Disorders	Tumor or Cancer
Anemia	Dizziness	Herpes	Pneumonia	
Arthritis	Epilepsy	High Blood Pressure	Prolonged Bleeding	
Asthma or Hay Fever	Gastrointestinal Disorders	Kidney Involvement	Rheumatic Fever	
Bone Disorders	Heart Problems	Liver Involvement	Tuberculosis	

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

If child, have you reached puberty? Girls-have you started menstruation? _____ Boys-has your voice changed? _____

Dentist

Dentist _____ Date of last cleaning _____

Address _____ Phone _____ Fax _____

Orthodontic Concerns

PLEASE describe what concerns you most about your teeth _____

Dental History

YES NO Are you presently in any dental *pain*? _____

YES NO Have you ever experienced any unfavorable reaction to dentistry? _____

YES NO Have you ever lost or chipped any teeth? _____

YES NO Have there ever been any injuries to face, mouth, or teeth? _____

YES NO Is any part of your mouth sensitive to temperature or pressure? _____

YES NO Do your gums bleed when you brush? _____

YES NO Do you have any type of thumb or tongue habit? _____

YES NO Are you a mouth breather? _____

YES NO Have you ever seen an orthodontist? _____

YES NO Has anyone in the family received orthodontic treatment? _____

YES NO How did they feel about the result? _____

YES NO What is your attitude toward receiving orthodontic treatment? _____

YES NO Do you have any pain or soreness around your face, neck or back? _____

YES NO Are your teeth or jaws ever uncomfortable when you awaken in the morning? _____

YES NO Are you aware of your jaw clicking or popping? _____

YES NO Are you aware of clenching your teeth during the day? _____

YES NO Have you ever been told that you grind your teeth? _____

YES NO Do you have "tension" headaches? _____

YES NO Have you ever experienced ringing in your ears? _____

YES NO Are you aware that some appointments will be during school/work hours? _____

Benefits of Orthodontics

AESTHETICS, HEALTH AND FUNCTION

Orthodontics is a service that provides an improvement in the appearance of the teeth, and in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases.

I hereby state that I have read and understand the above paragraph and that I have truthfully, to the best of my ability, answered all the above questions.

Patient/Parent

Date