Madison Pediatric Dental & Orthodontics
100 River Place, Suite 110
Madison WI 53716

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Today's Date ____________________

Child's Name ____________________ Age ______ Sex ______ Date of Birth ____________________
Address ____________________
Parent's Name ____________________ Parent's Name ____________________
Parent's Address ____________________ Parent's Address ____________________
City, State, Zip ____________________ City, State, Zip ____________________
Parent Home/Cell Phone ____________________ Parent Home/Cell Phone ____________________
Parent's Employer ____________________ Parent's Employer ____________________
Parent's Email Address ____________________ Parent's Email Address ____________________
Child's Dentist ____________________ Child's Physician ____________________ Referred by ____________________
Is patient covered by insurance for Orthodontic Care? Yes No
If yes, by which insurance company? ____________________

HEALTH HISTORY

Has the patient ever had:

- ❐ Asthma
- ❐ Blood Disease
- ❐ Diabetes
- ❐ Endocrine Problems
- ❐ Heart Disease
- ❐ Head/Face Injury
- ❐ Anemia
- ❐ Bone Disorders
- ❐ Epilepsy
- ❐ Emotional Problems
- ❐ Hearing Disorder
- ❐ Rheumatic Fever
- ❐ Other:

____

Does the patient:

1. Have allergies to: Seasonal Grasses ____________________ Food ____________________
   Drugs/Medications ____________________ Other ____________________
2. Snore when sleeping? Yes No
3. Breathe through mouth? Yes No
4. Have frequent colds? Yes No
5. Have frequent sore throat or tonsillitis? Yes No
6. Have chewing or swallowing difficulty? Yes No

Has the patient received medical treatment from allergist or ear, nose, and throat specialist? Yes No
If yes: When ____________________ By whom ____________________
Tonsils Removed ____________________ Adenoids removed ____________________

Onset of Puberty:
Adolescent girls: Have you started menses? Yes No If so, at what age: _____
Adolescent boys: Change in voice? Yes No If so, at what age: _____
Patient's Height ______ **Mother's Height** ______ **Father's Height** ______ Is the patient adopted? Yes No

Does the patient have pain or clicking in jaw joint? Yes No
Have any teeth been injured due to accidents or blows to the mouth? Yes No
Has the patient received or been requested to receive speech correction? Yes No

The following habits are of interest for orthodontic treatment. List all information as it pertains to this patient:
Thumb sucking until age ____________________ Grinding of teeth Yes No
Finger sucking until age ____________________ Tongue thrusting Yes No
Lip biting or sucking Yes No Other habits Yes No

Has the patient had any unusual dental experiences? Yes No
If yes, please specify: ____________________
Has the patient had previous orthodontic consultation or treatment? Yes No
If yes: Date ____________________ Dr. ____________________
Are there any other medical, dental or surgical problems not covered above? Yes No

PATIENT'S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:

Dental Checkups: Twice A Year Once A Year Only if Urgent Never
Date of last dental checkup ____________________ Were the patient's teeth cleaned? Yes No
Is the patient aware of any orthodontic problems? Yes No
Patient's interest in orthodontic treatment:
The patient wants: Treatment Treatment if Necessary Unwilling but Agrees Uncooperative
Orthodontic consultation prompted by: Patient Dentist Mother Father Physician