Madison Pediatric Dental & Orthodontics
220 West Broadway
Madison, WI 53716

Dr. Thomas Wenham, DMD
Orthodontist

Today's Date _____

Child's Name _____ **Preferred Name** _____
Age _____ **Date of Birth** _____ **Sex** _____ **Gender Identity** _____ **Pronouns** _____
Child's Address _____
Parent/ Legal Guardian's Name _____ Parent/ Legal Guardian's Name _____
Relationship to Patient_____ Relationship to Patient: _____
Street Address _____ Street Address _____
City, State, Zip _____ City, State, Zip _____
Home/Cell Phone _____ Home/Cell Phone _____
Employer _____ Employer _____
Email Address _____ 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: _____

Please List current medications: _____

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