great smiles ORTHODONTICS

Dr. Christy Jebeles Savage

Date _____

PATIENT INFORMATION

Last Name	First Name	Child Goes By	S.S. Number	Sex	Date of Birth	Age

Address	City	State	Zip	Home Phone

School (If a Student)	Grade	Is the patient adopted?	Cell Phone

Email Address: Add to Mailing List ☐

Siblings (Name and Age)	Hobbies/Interests

Referred By	Name of General Dentist	Date of Last Visit

PARENT INFORMATION

Father's Name	single ☐ married ☐ separated ☐ divorced ☐ widow(er) ☐	Mailing Address	City	State	Zip	Home Phone
Social Security No.		Birthdate	Employed By/Occupation			Cell Phone / Business Phone

Mother's Name	single ☐ married ☐ separated ☐ divorced ☐ widow(er) ☐	Mailing Address	City	State	Zip	Home Phone
Social Security No.		Birthdate	Employed By/Occupation			Cell Phone / Business Phone

E-Mail Address: Add to Mailing List ☐

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

Name	Relationship to Patient	Employed By/Occupation	Phone

Mailing Address	City	State	Zip	Business Phone

Spouse's Name	Employed By/Occupation	Phone

MEDICAL / DENTAL HISTORY

Is the patient in good health? _____ Yes ☐ No ☐

Does the patient have any history of major illness? _____ Yes ☐ No ☐

_____

Has the patient ever been under the care of a physician? _____ Yes ☐ No ☐

Please list: _____

Has there been any injuries to the face, mouth, or teeth?_____ Yes ☐ No ☐

_____

Has the patient ever sucked a thumb or fingers? At what age?_____ Yes ☐ No ☐

_____

Does the patient have any speech problems?_____ Yes ☐ No ☐

Is the patient a mouth breather? While awake? While asleep? _____ Yes ☐ No ☐

Have you been informed of any missing or extra permanent teeth? _____ Yes ☐ No ☐

Has either parent had orthodontic treatment?_____ Yes ☐ No ☐

Has an orthodontist been consulted previously? _____ Yes ☐ No ☐

Has the patient reached puberty? _____ Yes ☐ No ☐

Girls - Has she started menstruation? At what age? _____ Yes ☐ No ☐

Boys - Has his voice changed? At what age? _____ Yes ☐ No ☐

Have tonsils and adenoids been removed? What age? _____ Yes ☐ No ☐

Height: _____ Weight: _____

Please check any of the following conditions or problems.

Asthma	☐	Fainting/dizziness	☐
Bone (fracture)	☐	Hearing	☐
Seizures	☐	Heart Trouble	☐
Diabetes	☐	Kidney Trouble	☐
Endocrine (Hormone)	☐	Liver Trouble	☐
Epilepsy	☐	Mumps	☐
Emotional Disorder	☐	Rheumatic Fever	☐
Excessive bleeding	☐	Speech Disorder	☐
Eye	☐	Tuberculosis	☐
AIDS	☐	Hepatitis	☐

Other: _____

_____

List any drugs or medications now being taken. Give reasons: _____

_____

_____

List any allergies or drug sensitivity: _____

Do you have orthodontic insurance? Yes ☐ No ☐ Name of Company?

Policy #

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of the account.

_____

Signature (parent if patient is a minor)