Freeland Orthodontics
Dr. Dori Freeland DDS.MS.

CHILD'S ORTHODONTIC ACQUAINTANCE

Date:_____

Patient's Name:_____ Nickname_____

Date of Birth_____ Age_____ Sex □ male □ female

Address_____ City_____ Zip_____

Telephone (home) (_____)_____ Cell Phone (mom/dad)_____

Telephone (mom work) (___)_____ (dad work) (___)_____

Dentist_____ City_____ Telephone (___)_____

Physician_____ City_____ Telephone(___)_____

School_____ City_____ Grade_____

Sports/hobbies/etc._____

How would you like your appointment confirmed? □ Phone_____ □ e-mail_____

Family History

Parents: □ Married

□ Divorced, child lives with _____

□ Separated, child lives with_____

□ Mother deceased

□ Father deceased

□ Child adopted

Responsible Party (financial/ appointment scheduling)_____

Father's name_____ Occupation_____

Address_____ City_____ State___ Zip_____

Employer's name and address_____

Mother's name_____ Occupation_____

Address_____ City_____ State___ Zip_____

Employer's name and address_____

Names and ages of brothers and sisters_____

Other family members with orthodontic treatment (including parents)_____

Have you had any other experience with or seen another orthodontist? □ no □ yes

Dental Insurance Information

Subscriber name_____ Date of birth_____ Social Security or ID# _____

Address_____ City_____ State___ Zip_____

Employer name_____

Address_____ City_____ State___ Zip_____

Insurance Company_____

Address_____ City_____ State___ Zip_____

Telephone (___)_____ Group #_____

Questions for your insurance company:

Orthodontic maximum?_____ What percentage is the policy payable?_____

Secondary Dental Insurance Information

Subscriber name_____ Date of birth_____ Social Security or ID# _____

Address_____ City_____ State___ Zip_____

Employer name_____

Address_____ City_____ State___ Zip_____

Insurance Company_____

Address_____ City_____ State___ Zip_____

Telephone (___)_____ Group #_____

Please complete second page

Patient's name:_____

Medical History

General Health □good □ fair □ poor Presently under medical care for_____
Medication currently being taken (drug and dose)_____
Medication allergies_____
Latex allergies_____
Do you need to premedicate for dental appointments? □yes □ no

Please check yes or no to the following and date:

	yes	no	year		yes	no	year
Adenoids (removed)	__	__	_____	Heart disorder/murmur	__	__	_____
Arthritis	__	__	_____	Hepatitis	__	__	_____
Blood/bleeding problems	__	__	_____	HIV	__	__	_____
Bone disorder	__	__	_____	Hospitalized	__	__	_____
Diabetes	__	__	_____	Lung disorder	__	__	_____
Ear/nose infections	__	__	_____	Rheumatic fever	__	__	_____
Emotional	__	__	_____	Scoliosis	__	__	_____
Endocrine	__	__	_____	Speech difficulty	__	__	_____
Epilepsy	__	__	_____	Tonsils (removed)	__	__	_____
Fainting spells	__	__	_____	Sexually transmitted			
Glaucoma	__	__	_____	disease	__	__	_____
Currently pregnant (females)	__	__					

Please give any additional information or details necessary_____
_____

Maturation

Have you grown very much in the past year? □ yes □ no How many inches?_____
Female patients: Monthly periods? □ yes □ no Started at age_____
Male patients: Voice change? □ yes □ no Facial hair? □ yes □ no

Dental History

Date of last dental check-up_____
Injury or trauma to the face or teeth_____
Bruxism (teeth grinding) □ yes □ no
Clenching teeth □ yes □ no
Difficulty sleeping □ yes □ no
Mouth breathing □ yes □ no
Snoring □ yes □ no
Speech (difficulty in pronunciation) □ yes □ no
TMJ (Jaw Joint) □ clicking/noise □ pain □ earaches/ringing □ locking
□ muscle soreness □ frequent headaches

Describe major reason for seeking orthodontic treatment_____
Other family members with similar dental conditions_____
Other family members with orthodontic treatment_____
Have you had any experience with or seen another orthodontist?_____
Any additional comments_____
How and when did you first hear about our office?_____
Whom may we thank for referring you to our office?_____

Please complete third page

Patient Name:_____

PATIENT MOTIVATION FOR TREATMENT

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us understand your problem by checking the following information; please be specific (circle the words *more, less, forward, backward, longer, shorter, etc)*

1. **PATIENTS TREATMENT ATTITUDE**
   Major reason for seeking treatment:_____
   How did you become aware of the orthodontic problem?_____
   Patient's interest in treatment:
   □ patient wants treatment, , □ unwilling, but agrees, □treatment if necessary, □ uncooperative
2. **The Teeth**
   If your teeth could be changed how would you like them to change?
   - □ straighten the front teeth upper/lower
   - □ straighten the back teeth upper/lower
   - □ make the upper front teeth longer/shorter
   - □ move upper teeth forward/backward
   - □ move lower teeth forward/backward
   - □ make the line of the upper front teeth more level
   - □ other

3. **THE FACE**
   If your facial appearance could be changed, what would you change?
   - □ move chin forward/backward
   - □ move chin left/right
   - □ move lower lip forward/backward
   - □ move upper lip forward/backward
   - □ make the profile of my nose longer/shorter
   - □ move the area under my eyes forward/backward
   - □ make the cheekbones larger/smaller
   - □ show more/less of my teeth/gums when I smile
   - □ make my lips closer together / further apart when my teeth are touching
   - □ make my lips not touch and roll out when my teeth are touching
   - □ reduce the strain in my chin/lips when I close my lips
   - □ make my face more narrow/wide
   - □ reduce the width / fullness of my lower jaw behind my mouth
   - □ other:

4. **SYMPTOMS**
   If you want to reduce pain or discomfort where would it be located? Please be specific about the location; circle the right side, left side or both if they apply.
   - □ in front of my ears right/left
   - □ below my ears right/left
   - □ above my ears right/left
   - □ in my ears right/left
   - □ neck right/left
   - □ shoulders right/left
   - □ temples right/left
   - □ teeth
   - □ sinuses
   - □ eyes right/left
   - □ other:

Parent/Responsible Party Signature:_____Date_____