Cosmopolitan ORTHODONTICS

# Child Orthodontic Record

## PATIENT INFORMATION

Last Name _____ First Name _____ Preferred Name _____
Birth Date ____ / ____ / _____ Age _____ Sex M [ _ ] F [ _ ] School _____ Grade _____
Address _____ City _____ State _____ Zip _____
Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____
Activities/Hobbies _____ Ages of Siblings (____) (____) (____) (____)
Has any family member received treatment at our office? Yes [ _ ] No [ _ ] if yes, who? _____
Dentist _____ Whom may we thank for referring you? _____

## RESPONSIBLE PARTY INFORMATION

Last Name _____ First Name _____ Birth Date ____ / ____ / _____ Marital Status _____
Address _____ City _____ State _____ Zip _____
Time at this address _____ Relationship to patient _____ Email _____
Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____
Current Employer _____ Occupation _____
Spouse's Name _____ Birth Date ____ / ____ / _____ Relationship to patient _____
Current Employer _____ Occupation _____
Work Phone (_____) _____ - _____ May we call you/spouse at work? Yes [ _ ] No [ _ ] Email _____

*If a parent (responsible party) is not living with the patient, please complete the following*
Last Name _____ First Name _____ Birth Date ____ / ____ / _____
Address _____ City _____ State _____ Zip _____
Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

## ORTHODONTIC INSURANCE INFORMATION

Insurance Company (Primary) _____
Address _____
Phone Number (_____) _____ - _____
Group Number _____
Policy Holder Name _____
Policy Holder Soc. Sec. No. _____ - _____ - _____
Policy Holder Birth Date ____ / ____ / _____
Policy Holder Employer _____

Insurance Company (Secondary) _____
Address _____
Phone Number (_____) _____ - _____
Group Number _____
Policy Holder Name _____
Policy Holder Soc. Sec. No. _____ - _____ - _____
Policy Holder Birth Date ____ / ____ / _____
Policy Holder Employer _____

## INITIAL EXAM INFORMATION

What is your chief concern in seeking orthodontic care? _____
What is your dentist's main concern regarding the patient's bite? _____
In an effort to avoid records duplication: has another orthodontist been consulted previously? Yes [ _ ] No [ _ ]

**Our policy is that the parent/guardian who requests treatment is responsible for all fees for services rendered. When appropriate, credit information will be obtained.**

**Signature** _____ **Date** ____ / ____ / _____

## SIGNATURE ON FILE

By signing below:

- I authorize the use of this form and its information for all my insurance submissions.
- I authorize this office and its employees to act as my agent in helping me obtain insurance reimbursement.
- I authorize insurance payment directly to this office.
- I authorize the use of a copy of this form which can be used in place of the original.
- I understand where appropriate a credit report may be obtained.

**Signature** _____ **Date** ____ / ____ / _____

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## MEDICAL HISTORY

Name of patient's physician _____ Physician's Phone (_____) _____ - _____

**please check yes or no for each condition (if yes, please explain)**

*Allergies*
Yes [ _ ] No [ _ ] Acrylic
Yes [ _ ] No [ _ ] Aspirin
Yes [ _ ] No [ _ ] Ibuprofen
Yes [ _ ] No [ _ ] Latex
Yes [ _ ] No [ _ ] Metals
Yes [ _ ] No [ _ ] Nickel
Yes [ _ ] No [ _ ] Vinyl
Yes [ _ ] No [ _ ] Other _____

Yes [ _ ] No [ _ ] Arthritis (Rheumatism)
Yes [ _ ] No [ _ ] Asthma
Yes [ _ ] No [ _ ] Attention Deficit Disorder

*Blood disorders*
Yes [ _ ] No [ _ ] Anemia
Yes [ _ ] No [ _ ] Bruise easily
Yes [ _ ] No [ _ ] Excessive bleeding
Yes [ _ ] No [ _ ] Other _____

*Blood pressure conditions*
Yes [ _ ] No [ _ ] high
Yes [ _ ] No [ _ ] low

Yes [ _ ] No [ _ ] AIDS or HIV positive

Yes [ _ ] No [ _ ] Cancer
Yes [ _ ] No [ _ ] Chemo
Yes [ _ ] No [ _ ] Radiation

*Cardiovascular conditions*
Yes [ _ ] No [ _ ] Angina
Yes [ _ ] No [ _ ] Heart attack
Yes [ _ ] No [ _ ] Heart defect
Yes [ _ ] No [ _ ] Heart murmur
Yes [ _ ] No [ _ ] Stroke
Yes [ _ ] No [ _ ] Other _____

*Neurological disorders*
Yes [ _ ] No [ _ ] Epilepsy
Yes [ _ ] No [ _ ] Fainting
Yes [ _ ] No [ _ ] Seizures
Yes [ _ ] No [ _ ] Other _____

Yes [ _ ] No [ _ ] Eating disorder
Yes [ _ ] No [ _ ] Headaches/migraines
Yes [ _ ] No [ _ ] Hepatitis
Yes [ _ ] No [ _ ] Immune system disorder
Yes [ _ ] No [ _ ] Kidney disorders

Yes [ _ ] No [ _ ] Oral ulcers
Yes [ _ ] No [ _ ] Respiratory problems
Yes [ _ ] No [ _ ] Rheumatic fever

*Sensory conditions*
Yes [ _ ] No [ _ ] Hearing
Yes [ _ ] No [ _ ] Tasting
Yes [ _ ] No [ _ ] Vision
Yes [ _ ] No [ _ ] Other _____

Yes [ _ ] No [ _ ] Speech condition (if yes, explain)
_____

Yes [ _ ] No [ _ ] Tonsils/adenoids
Yes [ _ ] No [ _ ] Tuberculosis

Yes [ _ ] No [ _ ] Does your child have any other medical conditions that we should know about?

If yes, please explain _____
_____
_____
_____
_____

## MEDICATION HISTORY

Yes [ _ ] No [ _ ] Is your child taking any prescription medication,over the counter medication, nutritional supplements, or herbal medication?

**Please list all medications...**

| Medication | Taken for |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## DENTAL HISTORY

Yes [ _ ] No [ _ ] Does the patient have missing teeth?
Yes [ _ ] No [ _ ] Does the patient have extra teeth?
Yes [ _ ] No [ _ ] Does the patient have slowly erupting teeth?
Yes [ _ ] No [ _ ] Does the patient have unerupted teeth?
Yes [ _ ] No [ _ ] Does the patient have thin gum tissue?
Yes [ _ ] No [ _ ] Does the patient brush and floss regularly?
Yes [ _ ] No [ _ ] Is the patient in good dental health?
Yes [ _ ] No [ _ ] Are the patient's x-rays and fluoride treatments up to date?
Yes [ _ ] No [ _ ] Has the patient seen the dentist in the past six months?
Yes [ _ ] No [ _ ] Is the patient cooperative/ helpful during dental treatment?
Yes [ _ ] No [ _ ] Has the patient experienced any unusual dental problems?
Yes [ _ ] No [ _ ] Is there anything else about your child's dental history that we should know about?

If yes to any above, please explain _____

**Now or in the past has your child had...**

Yes [ _ ] No [ _ ] ...any history of injured teeth?
Yes [ _ ] No [ _ ] ...injury to the head, neck, or jaws?
Yes [ _ ] No [ _ ] ...tooth sensitivity to hot or cold?
Yes [ _ ] No [ _ ] ...history of dental problems?
Yes [ _ ] No [ _ ] ...periodontal or "gum tissue" problems?
Yes [ _ ] No [ _ ] ...bleeding gums when brushing?
Yes [ _ ] No [ _ ] ...food impaction between teeth?
Yes [ _ ] No [ _ ] ...frequent canker sores or cold sores?

*Jaw joint history*

Yes [ _ ] No [ _ ] ...history of jaw joint pain?
Yes [ _ ] No [ _ ] ...history of jaw joint clicking or locking?
Yes [ _ ] No [ _ ] ...history of facial muscle pain
Yes [ _ ] No [ _ ] ...difficulty chewing, opening, or closing?
Yes [ _ ] No [ _ ] ...history of treatment for TMD or TMJ?

*Functional/habit history*

Yes [ _ ] No [ _ ] ...history of thumb or finger habit?
Yes [ _ ] No [ _ ] ...history of tongue thrusting?
Yes [ _ ] No [ _ ] ...history of abnormal swallowing?
Yes [ _ ] No [ _ ] ...difficulty eating?
Yes [ _ ] No [ _ ] ...history of mouthbreathing?
Yes [ _ ] No [ _ ] ...history of snoring?
Yes [ _ ] No [ _ ] ...history of tooth grinding?
Yes [ _ ] No [ _ ] ...history of jaw clenching?
Yes [ _ ] No [ _ ] ...history of speech difficulty?
Yes [ _ ] No [ _ ] ...any history of speech therapy?

If yes to any above, please explain _____

Successful orthodontic treatment and beautiful smiles are achieved with a combination of appropriate diagnosis, excellent communication, and personalized attention. In an effort to specifically address your orthodontic concerns, please indicate what you would like orthodontics to accomplish for your family:

[ _ ] Enhance aesthetics and appearance
[ _ ] Create facial balance
[ _ ] Improve function, comfort, and stability
[ _ ] Increase self confidence
[ _ ] Enhance overall dental health
[ _ ] Avoid further problems

I have read and understand the previous questions and I certify that the information I have provided is complete and accurate. In addition I acknowledge that I am solely responsible for any errors or omissions that may have been made in the completion of this four page form. As the responsible party I will immediately inform this office in the event of any change in medical and/or dental health status and will acknowledge change in status by signing and dating below.

**Signature** _____ **On behalf of** _____ **Date** ____ / ____ / _____
(responsible party) (patient)

## MEDICAL / DENTAL HISTORY UPDATE

| Date | Medical/dental status change? | Signature | Change in status |
|---|---|---|---|
| | Yes [ _ ] No [ _ ] | | |
| | Yes [ _ ] No [ _ ] | | |
| | Yes [ _ ] No [ _ ] | | |
| | Yes [ _ ] No [ _ ] | | |
| | Yes [ _ ] No [ _ ] | | |
| | Yes [ _ ] No [ _ ] | | |
| | Yes [ _ ] No [ _ ] | | |
| | Yes [ _ ] No [ _ ] | | |
| | Yes [ _ ] No [ _ ] | | |
| | Yes [ _ ] No [ _ ] | | |
| | Yes [ _ ] No [ _ ] | | |
| | Yes [ _ ] No [ _ ] | | |

## FOR OFFICE USE ONLY

*Deciduous teeth present*

R E D C B A | A B C D E L
E D C B A | A B C D E

*Permanent teeth present*

R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

*Crossbites*

R ——— | ——— L

*Molar and Canine classification*

| | Right side | | Left side | |
|---|---|---|---|---|
| | Molar | Canine | Molar | Canine |
| Class I | | | | |
| End to End II | | | | |
| Class II | | | | |
| Class III | | | | |

*Skeletal*

| | R | L | |
|---|---|---|---|
| Class I | [ _ ] | [ _ ] | |
| Class II | [ _ ] | [ _ ] | |
| Class III | [ _ ] | [ _ ] | |
| Upper midline | [ _ ] | [ _ ] | _____ mm |
| Lower midline | [ _ ] | [ _ ] | _____ mm |

| | Mild | Moderate | Severe |
|---|---|---|---|
| Upper Crowding | [ _ ] | [ _ ] | [ _ ] |
| Lower Crowding | [ _ ] | [ _ ] | [ _ ] |

Overbite _____ %
Frenum Inv. [ _ ] Not Inv. [ _ ]
Midline Diastema _____ mm
Overjet _____ mm

| Date | Recommendation |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |