WELCOME TO AMHERST ORTHODONTICS

The contents of this form are strictly confidential and become part of the dental record.

PATIENT INFORMATION

Child's Name:		Prefers to be called:
☐Male ☐Female	Date of Birth:	School:
Grade:	Hobbies:	
Siblings and ages:		

PRIMARY RESIDENCE/GUARDIAN INFORMATION

Title, First, Last Name:	
Relationship to patient:	Email:
Mailing address:	
Phone (home):	Phone (cell):
Phone (work):	Employer/Occupation:
Title, First, Last Name:	
Relationship to patient:	Email:
Mailing address:	
Phone (home):	Phone (cell):
Phone (work):	Employer/Occupation:

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Partnered ☐Widowed

Should each parent receive separate correspondence? ☐Yes ☐No

Please indicate how you would like to get appointment reminders? ☐Phone ☐Email ☐Text ☐All

ORTHODONTIC HISTORY AND EVALUATION

What is motivating you to seek an orthodontic opinion? (check all that apply)

☐ baseline evaluation ☐dentist referred ☐longterm dental health ☐cosmetics
☐ 2nd opinion ☐Invisalign ☐other:_____

What do you value when seeking an orthodontic office for your family? (check all that apply)

☐ patient education ☐rewards ☐communication ☐appointment shuttle
☐ upbeat/friendly ☐excellent results ☐flexible financing ☐doctor qualifications
☐ treatment area open to parents ☐other:_____

ORTHODONTIC HISTORY AND EVALUATION (CONT.)

Please list any family members who have received orthodontic treatment?

Has your child ever been evaluated for, or previously had, orthodontic treatment?

DENTAL HISTORY

Child's Dentist:	Date of last cleaning:
Pending dental work? ☐ Yes ☐ No	Have there been any bumps to the head, face, or teeth? ☐ Yes ☐ No

What is your child's comfort level in a dental environment? (1 =fine, 5 = extremely anxious)

Does your child require pre-medication for dental visits? ☐ Yes ☐ No

Does your child (please check all that apply) ☐ chew ice? ☐ Bite nails? ☐ Chew gum?

Has your child had tooth extractions ☐ Ye ☐ No If Yes, with whom:

MEDICAL HISTORY

Is your child in good health? ☐ Yes ☐ No	Has your child reached puberty? ☐ Yes ☐ No ☐ Current

Please check any which apply to your child, including those that they have been treated or those which have stopped:

☐ Seasonal allergies	☐ Bone disorders	☐ Lip sucking/biting
☐ Latex allergy	☐ Chronic Cold Sores	☐ Migraines/Regular headaches
☐ Metal allergy	☐ Diabetes	☐ Mouthbreather
☐ ADHD	☐ Epilepsy or Convulsions	☐ Speech therapy
☐ Arthritis	☐ Heart murmur or conditions	☐ Chronic Sinus Trouble
☐ Asperger's Syndrome	☐ Grinding or clenching of jaws	☐ Snoring
☐ Asthma	☐ Clicking or Popping Jaw joints	☐ Tonsillectomy/Adenoidectomy
☐ Autism/Spectrum Disorder	☐ Locking of jaws	☐ Thumb/finger sucking
☐ Bleeding disorders	☐ Jaw pain	☐ Other: _____

Please list any medicines your child is taking:

Are there any other issues we should be aware of?

Thank you for taking the time to help us create the most informative first visit! Please help us to THANK the individual who referred you. How did you hear about us?

Hygienist (name): _____ School Visit by the Doctors ☐

Advertisement: _____ Dentist ☐

Friend/coworker/neighbor: _____

Internet Search, keywords: _____ Other: _____

Parent/Guardian Signature: _____ Date: _____