Alameda Pediatric Dentistry
ORTHODONTICS

In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

Patient Information – Child or Teen

Patient Name:_____ Age:_____ Date of Birth:_____

Mother's Name :_____Father's Name:_____

Best day time #:_____ ☐ Home ☐ Cell ☐ Work Relationship_____

Alternate #:_____ ☐ Home ☐ Cell ☐ Work Relationship_____

Does the child live with both parents in the same home? ☐ Yes ☐ No

Email_____

Dental History

☐ Yes ☐ No Have there been any severe injuries to the face? Please describe_____

☐ Yes ☐ No Are you aware of any missing or extra teeth? Which ones? _____

☐ Yes ☐ No Does the patient suck ☐ thumb ☐ fingers ☐ tongue ☐ blanket ☐ pacifier
If so, until what age?_____

☐ Yes ☐ No Does the patient breathe predominantly through the mouth?

☐ Yes ☐ No Does the patient take any pills or medications for dental reasons?_____

☐ Yes ☐ No Has the patient seen a ☐ periodontist ☐ endodontist ☐ oral surgeon

☐ Yes ☐ No Has the patient had previous orthodontic treatment or consultation?_____

☐ Yes ☐ No Has any member of the family had orthodontic treatment?_____

☐ Yes ☐ No Does the patient have any dental, facial pain or joint pain?

☐ Yes ☐ No Does the patient habitually grind or clench teeth together?

☐ Yes ☐ No Does the patient have any negative or resistant feelings about orthodontic treatment?
Specifically, ☐ braces ☐ headgear ☐ retainers?

☐ Yes ☐ No Is the patient dissatisfied about the appearance of their ☐ teeth ☐ smile ☐ gums
☐ chin ☐ nose ☐ lips ☐ other:_____

☐ Yes ☐ No Is there any other dental information we should know? _____
_____

Signature:_____Date:_____
(Responsible party signature if patient is a minor)

Member American Association of Orthodontists®
My Life. My Smile. My Orthodontist.®