

Ronconi Orthodontics

CHILD

SS _____

We are pleased that you called our office for your Orthodontic Evaluation. At this appointment a preliminary evaluation and diagnosis will be made. The visit will take approximately one hour. If orthodontic treatment is indicated, arrangements will be made to take diagnostic records. To make the most efficient use of your time, we request that you please complete the following questionnaire and bring with you to your appointment.

Patient's Full Name _____ Sex: M / F / _____ Age _____ Birthdate _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ School _____ Grade _____

Father/Guardian _____ Marital Status: S/M/D/W _____ SS # _____ Birthdate _____
Address _____ Rent/Own _____ Hm/Cell Ph _____ Email _____
Employer _____ Occupation _____ How Long? _____

Business Address _____ Wk Ph _____ City _____
Mother/Guardian _____ Marital Status: S/M/D/W _____ SS # _____ Birthdate _____
Address _____ Rent/Own _____ Hm/Cell Ph _____ Email _____
Employer _____ Occupation _____ How Long? _____
Business Address _____ Wk Ph _____ City _____

Any immediate family members treated here? Yes No If yes, their names are _____

What is the primary reason for your visit today? _____

Primary Orthodontic Insurance _____ Group # _____ Plan # _____
Insured Employee _____ Birthdate _____ SS # _____
Secondary Orthodontic Insurance _____ Group # _____ Plan # _____
Insured Employee _____ Birthdate _____ SS # _____
Person Responsible for account _____ Relationship _____

I authorize a review of my credit necessary to qualify for office payment plans : Yes No

DENTAL HISTORY: Patient's Dentist _____ City _____

Has the patient ever had any injuries to the face/mouth/teeth? Yes No Is the patient a mouth breather? Yes No
Have you ever had any jaw clicking or popping? Yes No If yes, Awake Asleep
Are there any missing or extra permanent teeth? Yes No Has the patient had a Thumb/Finger sucking habit?
Has an orthodontist been consulted previously Yes No Yes No
Until what age? _____

MEDICAL HISTORY: Patient's Physician _____ City _____

Is patient in good health? Yes No Does patient have tendency to : Colds
Does patient have any history of major illness? Yes No Ear Infections
Have tonsils or adenoids been removed? Yes No Sore Throats

List any medications now being taken. Give reasons. _____

List any allergies or medication sensitivities: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N	Anemia <input type="checkbox"/> Y <input type="checkbox"/> N	Prolonged Bleeding <input type="checkbox"/> Y <input type="checkbox"/> N
Auto Immune Diseases <input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N	Fainting or Dizziness <input type="checkbox"/> Y <input type="checkbox"/> N
Heart Trouble <input type="checkbox"/> Y <input type="checkbox"/> N	Asthma <input type="checkbox"/> Y <input type="checkbox"/> N	Nervous Disorders <input type="checkbox"/> Y <input type="checkbox"/> N
Rheumatic Fever <input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Involvement <input type="checkbox"/> Y <input type="checkbox"/> N	Liver Involvement <input type="checkbox"/> Y <input type="checkbox"/> N
Bone Disorders <input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis <input type="checkbox"/> Y <input type="checkbox"/> N	Arthritis <input type="checkbox"/> Y <input type="checkbox"/> N
Tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> N	Endocrine Problems <input type="checkbox"/> Y <input type="checkbox"/> N	LATEX Allergy <input type="checkbox"/> Y <input type="checkbox"/> N