# Skelton Orthodontics

## PATIENT INFORMATION

| Last Name | First Name | Nickname | S.S. Number | Sex | Date of Birth | Age |
|---|---|---|---|---|---|---|
| | | | | | | |

| Address | City | State | Zip | Home Phone |
|---|---|---|---|---|
| | | | | Cell Phone |
| | | | | Business Phone |

| School (If a Student) | Grade | single ☐ married ☐ sep ☐ divorced ☐ widow(er) ☐ | Employed By/Occupation |
|---|---|---|---|
| | | | |

| Referred By | Name of General Dentist | Date of Last Visit |
|---|---|---|
| | | |

## PARENT INFORMATION (please complete if patient is a minor)

| Father's Name | single ☐ married ☐ separated ☐ divorced ☐ widower ☐ | Mailing Address | City | State | Zip | Home Phone |
|---|---|---|---|---|---|---|
| | | | | | | Cell Phone |
| Social Security No. | | Birthdate | Employed By/Occupation | | | Business Phone |
| Mother's Name | single ☐ married ☐ separated ☐ divorced ☐ widow ☐ | Mailing Address | City | State | Zip | Home Phone |
| | | | | | | Cell Phone |
| Social Security No. | | Birthdate | Employed By/Occupation | | | Business Phone |

E-Mail Address:

## INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

| Name | Relationship to Patient | Employed By/Occupation | Phone |
|---|---|---|---|
| | | | |

| Mailing Address | City | State | Zip | Business Phone |
|---|---|---|---|---|
| | | | | |

| Spouse's Name | Employed By/Occupation | Phone |
|---|---|---|
| | | |

## MEDICAL / DENTAL HISTORY

Is the patient in good health? _____ Yes ☐ No ☐
Does the patient have any history of major illness? _____ Yes ☐ No ☐
_____
Has the patient ever been under the care of a physician? _____ Yes ☐ No ☐
Please list: _____
Has there been any injuries to the face, mouth, or teeth? _____ Yes ☐ No ☐
_____
Has the patient ever sucked a thumb or fingers? At what age? _____ Yes ☐ No ☐
_____ Yes ☐ No ☐
Does the patient have any speech problems? _____ Yes ☐ No ☐
Is the patient a mouth breather? While awake? While asleep? _____ Yes ☐ No ☐
Have you been informed of any missing or extra permanent teeth? _____ Yes ☐ No ☐
Has either parent had orthodontic treatment? _____ Yes ☐ No ☐
Has an orthodontist been consulted previously? _____ Yes ☐ No ☐
Has the patient reached puberty? _____ Yes ☐ No ☐
Girls - Has she started menstruation? At what age? _____ Yes ☐ No ☐
Boys - Has his voice changed? At what age? _____ Yes ☐ No ☐
Have tonsils and adenoids been removed? What age? _____ Yes ☐ No ☐
Height: _____ Weight: _____

*Please check any of the following conditions or problems.*

| | | | |
|---|---|---|---|
| Asthma | ☐ | Fainting/dizziness | ☐ |
| Bone (fracture) | ☐ | Hearing | ☐ |
| Seizures | ☐ | Heart Trouble | ☐ |
| Diabetes | ☐ | Kidney Trouble | ☐ |
| Endocrine (Hormone) | ☐ | Liver Trouble | ☐ |
| Epilepsy | ☐ | Mumps | ☐ |
| Emotional Disorder | ☐ | Rheumatic Fever | ☐ |
| Excessive bleeding | ☐ | Speech Disorder | ☐ |
| Eye | ☐ | Tuberculosis | ☐ |
| AIDS | ☐ | Hepatitis | ☐ |

Other: _____
_____
List any drugs or medications now being taken. Give reasons: _____
_____
_____
List any allergies or drug sensitivity: _____

Do you have orthodontic insurance? Yes ☐ No ☐ Name of Company?

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of the account.

_____
Signature (parent if patient is a minor)