

Nellie Gail Orthodontics

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New Patient Information-Child

Today's Date: _____ Patient's Name _____

Male Female Age _____ Date of Birth _____

Address _____ Home Phone _____

Patient's school _____ Grade _____

Referred By: _____ Family Dentist _____

Father's Name _____ Home Phone _____

Address _____ City _____ Zip _____

Place of Employment _____ Business Phone _____

Mother's Name _____ Home Phone _____

Address _____ City _____ Zip _____

Place of Employment _____ Business Phone _____

Please provide the following information if you would like our office to check with your insurance carrier for orthodontic benefits:

Name of Insured _____ Date of Birth _____ SSN _____

Name of Insured _____ Date of Birth _____ SSN _____

Primary Ins. Co. _____ Group # or Plan Name _____

Secondary Ins. Co. _____ Group # or Plan Name _____

Instructions: Please answer all questions as completely and accurately as possible; your confidentiality will be respected.

What are your primary concerns that brought you/ your child to our office? _____

Please check any of the following that are concerns regarding the teeth and jaws:

- | | | |
|---|---|---|
| <input type="checkbox"/> crowding | <input type="checkbox"/> overbite | <input type="checkbox"/> buckteeth |
| <input type="checkbox"/> receded jaw | <input type="checkbox"/> prominent jaw | <input type="checkbox"/> gummy smile |
| <input type="checkbox"/> spaces | <input type="checkbox"/> gum disease or recession | <input type="checkbox"/> missing teeth |
| <input type="checkbox"/> jaw dysfunction | <input type="checkbox"/> clicking jaw joint | <input type="checkbox"/> mouth too small |
| <input type="checkbox"/> irregularly shaped teeth | <input type="checkbox"/> protrusion of teeth | <input type="checkbox"/> ringing/stuffiness of ears |
| <input type="checkbox"/> headaches/facial pain | <input type="checkbox"/> neck pain | <input type="checkbox"/> jaw pain |
| <input type="checkbox"/> irregular facial proportions | <input type="checkbox"/> other _____ | |

Do any blood relatives have similar problems? Father Mother brother sister other _____

The following are also of interest to the orthodontist: Please check yes or no. Does the patient

- | | | | | | |
|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|--|
| YES | NO | | YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | snore when sleeping | <input type="checkbox"/> | <input type="checkbox"/> | breathe primarily through the mouth |
| <input type="checkbox"/> | <input type="checkbox"/> | have frequent colds | <input type="checkbox"/> | <input type="checkbox"/> | have frequent sore throat or tonsillitis |
| <input type="checkbox"/> | <input type="checkbox"/> | have difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> | have difficulty chewing |
| <input type="checkbox"/> | <input type="checkbox"/> | have pain in the jaw joint | <input type="checkbox"/> | <input type="checkbox"/> | have clicking in the jaw joint |
| <input type="checkbox"/> | <input type="checkbox"/> | have speech problems | <input type="checkbox"/> | <input type="checkbox"/> | smoke |
| <input type="checkbox"/> | <input type="checkbox"/> | suck finger or thumb (ever? Y/N) | <input type="checkbox"/> | <input type="checkbox"/> | bite or suck on lip |
| | | If previously, age ceased _____ | <input type="checkbox"/> | <input type="checkbox"/> | grind teeth |
| <input type="checkbox"/> | <input type="checkbox"/> | tongue thrust | <input type="checkbox"/> | <input type="checkbox"/> | other habits _____ |

Dental history and patient's interest in orthodontic treatment:

- Dental checkups once a year twice a year only if urgent never
- Is the patient aware of any orthodontic problems? yes no
- Patient's interest in orthodontic treatment:
 wants treat if necessary unwilling, but agrees uncooperative
- Orthodontic consultation prompted by: patient dentist mother father _____
- Has the patient had previous orthodontic consultation or treatment? yes no
- Has the patient had any unusual dental experiences? yes no If yes, please explain _____

MEDICAL HISTORY

Present Health Good Fair Poor

Has the patient ever had any of the following conditions? Please check yes or no for each

- | | | | | | | | | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|---------------|
| YES | NO | | YES | NO | | YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Blood disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune disorder | <input type="checkbox"/> | <input type="checkbox"/> | Arteriosclerosis | <input type="checkbox"/> | <input type="checkbox"/> | heart disease |

- | | | | | | | | | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | bone disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | cancer | <input type="checkbox"/> | <input type="checkbox"/> | diabetes | <input type="checkbox"/> | <input type="checkbox"/> | dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | endocrine problems | <input type="checkbox"/> | <input type="checkbox"/> | hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | emotional problems | <input type="checkbox"/> | <input type="checkbox"/> | female problems | <input type="checkbox"/> | <input type="checkbox"/> | hearing disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | HIV+ | <input type="checkbox"/> | <input type="checkbox"/> | AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> | sleep disturbance | <input type="checkbox"/> | <input type="checkbox"/> | trauma to head |

Medications: Current medications taken by patient. Please check yes or no for each

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---------------------|
| YES | NO | | YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | bone density drugs (e.g. Fosamax, Boniva) | <input type="checkbox"/> | <input type="checkbox"/> | antibiotics |
| <input type="checkbox"/> | <input type="checkbox"/> | heart pills | <input type="checkbox"/> | <input type="checkbox"/> | Vitamins |
| <input type="checkbox"/> | <input type="checkbox"/> | pain pills (Codeine, Demerol, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | birth control pills |
| <input type="checkbox"/> | <input type="checkbox"/> | Diet Pills (diuretics, Phen-Fen, Redux, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | Insulin |
| <input type="checkbox"/> | <input type="checkbox"/> | sleeping pills | <input type="checkbox"/> | <input type="checkbox"/> | muscle relaxants |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ | | | |

Has the patient been on any medications in the past six months that the patient is not currently taking? Yes No
 If yes, please circle the YES boxes above for any medications that the patient is not currently taking but has taken within the past six months.

Allergies: The patient demonstrates an allergic response to

- | | | | | | |
|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|-------------------|
| YES | NO | | YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | latex | <input type="checkbox"/> | <input type="checkbox"/> | pain pills |
| <input type="checkbox"/> | <input type="checkbox"/> | metals _____ | <input type="checkbox"/> | <input type="checkbox"/> | antibiotics _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | dairy products/wheat/cereals | <input type="checkbox"/> | <input type="checkbox"/> | dyes in food |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ | | | |

Are there any other medical, dental, or surgical problems not covered above or any conditions an orthodontist, oral surgeon, or physician should know about? yes no If yes, please explain _____

Signature of person filling out form _____ Date _____

Relationship to patient _____

Doctor's Notes:
