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LAMPARSKI ORTHODONTICS

MEDICAL HISTORY

Patient Information

Date _____ Male _____ Female _____

Patient's Name _____ Nickname _____

Address _____ E-mail _____

Home Phone _____ Birth Date _____

Siblings (Name and Age) _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about our office? _____

Parent Information

Marital Status: Single Married Widowed Divorced Separated Domestic Partner

Father Is he responsible for payment? Yes No

Father Step-Father Guardian Name _____

Address (if different) _____ Birth Date _____ E-mail _____

Home Phone _____ Work Phone _____ Cell Phone _____ SS # _____

Employer _____ Employer's Phone _____

If you have orthodontic insurance: ID # _____

Insurance Company Name _____ Group or Plan # _____

Insurance Company Phone # _____ Insurance Company Address _____

Mother Is she responsible for payment? Yes No

Mother Step-Mother Guardian Name _____

Address (if different) _____ Birth Date _____ E-mail _____

Home Phone _____ Work Phone _____ Cell Phone _____ SS # _____

Employer _____ Employer's Phone _____

If you have orthodontic insurance: ID # _____

Insurance Company Name _____ Group or Plan # _____

Insurance Company Phone # _____ Insurance Company Address _____

Dental History

What goals do you want orthodontics to accomplish?				Dentist / last visit	
Past dental or facial trauma	Yes	No	Accidents or surgery to face, neck, mouth or teeth	Teeth broken, loosened or knocked out	Missing teeth
Jaw joint problems	Yes	No	Explain	Frequent headaches	Clenching or grinding
Oral problems	Yes	No	Canker/cold sores	Swollen/bleeding gums	Habits: thumb/finger Speech
Difficulty chewing or swallowing?	Yes	No	Previous orthodontic treatment or consultations	Orthodontist	Result
Siblings had orthodontics	Yes	No	Orthodontist	Result	
Parents had orthodontics	Yes	No	Orthodontist	Result	
Does anyone in the family have a similar dental condition, crowded, retruded or protruded teeth, protruding lower jaw or receding chin?					

Medical History

Present health:	Excellent	Good	Fair	Poor	Physician
Ever hospitalized	Yes	No	Explain		Does the patient have any of the following? <input type="checkbox"/> AIDS/HIV+ <input type="checkbox"/> Epilepsy <input type="checkbox"/> TB <input type="checkbox"/> Venereal disease <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Heart murmur / defect <input type="checkbox"/> Artificial joint <input type="checkbox"/> Hemophilia <input type="checkbox"/> Emotional problems
Chronic diseases	Yes	No	Explain		
Presently under physician care	Yes	No	Explain		
Presently on medication	Yes	No	Explain		
Allergies to latex or metal	Yes	No	Other allergies		
Complications to previous treatment	Yes	No	Explain		
Does the patient smoke or use tobacco	Yes	No	Explain		
Any diseases, conditions or problems the orthodontists should know about?					

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

I understand the information I provided is correct to the best of my knowledge and it is my responsibility to inform this office of changes in my child's medical status. I understand I am responsible for payment of services rendered and also responsible for paying any co-payment and/or deductibles my insurance does not cover. **I authorize the doctors and staff to perform the dental services my child needs.**

Signature of parent or guardian

Date