Highlands Ranch
Orthodontics, P.C.
For Children and Adults

303.791.2021
bracesbydarrell@gmail.com

Excellence in orthodontic care

KIDS PATIENT HISTORY INFORMATION FORM

Patient's Name______________________________Nickname________________________________SexÁÁT ____Ø____
Home Address____ City____________________ Zip___________________
School_________________________Grade___________ **E-mail**______________________´ ´ ´ ´ ´ ´ ´ ÁDOBÁ___ ___ ___
Home Phone ______________________________Patient's Physician and Phone___________________________________

Who will be financially responsible for the account? ____
Phone and Address of responsible party? ____
Orthodontic Insurance? _______**YES** ______ **NO** ____

Parents' Marital Status: Married________Separated________Divorced_______Widowed________

FATHER	**MOTHER**
Name ____	Name____
Address ____	Address ____
Phone ___________________Cell _____________________	Phone _________________Cell_____________________
Birth date ____	Birth date ______________________________________
Business Phone ____________________________________	Business Phone___________________________________
Occupation _______________________________________	Occupation______________________________________
Employer ____	Employer _______________________________________
E-Mail ____	E-Mail ____
Father's Dentist ____________________________________	Mother's Dentist ________________________________

PATIENT MEDICAL HISTORY

Is the patient experiencing any health problems? Yes____ No____Reason____________________________________
Any major or unusual illnesses? Yes____ No____Explain ____________________________________
Currently under physicians care? Yes____ No____Reason____________________________________
Currently taking medication? Yes____ No____List ____
Allergies? Yes____ No____List ____
Drug sensitivity or Drug Allergies? Yes____ No____List ____
Has the patient ever received blood transfusion? Yes____ No____Reason____________________________________

Please Check if Patient has or had any of the Following:

_____ Heart Murmur
_____ Anemia
_____ Blood Disease
_____ Prolonged Bleeding
_____ Diabetes
_____ Hepatitis
_____ Rheumatic Fever
_____ Herpes
_____ AIDS or AIDS Related Complex

_____ Has the patient ever been advised to take antibiotics prior to dental appointments (i.e.for heart problem)?

_____ Heart Disease
_____ Tuberculosis
_____ Endocrine (Hormone)
_____ Jaundice
_____ Bone Disorders
_____ Asthma
_____ Epilepsy (or Seizure disorder)

_____ Frequent Colds or Flu
_____ Mouthbreathing: While awake?
_____ Problems While asleep?
_____ Tonsillitis
_____ Tonsils Removed? Age:_____
_____ Adenoid infections or Sinus infections
Adenoids Removed? Age:_____

_____ Are you pregnant or is there a possibility that you could be pregnant?_____

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PATIENT MOTIVATION FOR TREATMENT

PATIENT NAME: ____

Patients often request changes of their bites, facial appearance changes or relief from pain or discomfort. Please help us understand your concerns by checking the following information; please be specific (**circle the appropriate words** *forward, backward, longer, shorter,* etc.):

1. The Teeth

If teeth could be changed, how would you like them to change?

[ ] straighten the front teeth [ ] *upper/lower* [ ]
[ ] straighten the back teeth [ ] *upper/lower* [ ]
[ ] make the upper teeth [ ] *longer/shorter* [ ]
[ ] move upper teeth [ ] *forward/backward* [ ]
[ ] move lower teeth [ ] *forward/backward* [ ]
[ ] make the line of the upper front teeth more level
[ ] ***close*** spaces between teeth or ***make*** spaces for teeth
[ ] other:

2. The Face

If facial appearance could be changed, what would you like to see changed?

[ ] move chin [ ] *forward/backward* [ ]
[ ] move chin [ ] *left/right* to center it [ ]
[ ] move lower lip [ ] *forward/backward* [ ]
[ ] move upper lip [ ] *forward/backward* [ ]
[ ] get rid of sag under lower jaw
[ ] move the area around the nose [ ] *forward/backward* [ ]
[ ] make the profile of the nose [ ] *longer/shorter* [ ]
[ ] move the area under the eyes [ ] *forward/backward* [ ]
[ ] make the cheekbones [ ] *larger/smaller* [ ]
[ ] show [ ] *{ [¦^Ð^••Á*] of my Á[ ] *Á^^c@Ð˘{ •* ÁÁ[ ] when I smile
[ ] make the lips [ ] *&|[•^¦Á[*^c@¦Ð˘¦c@¦Áæ} æ¦cÁ* [ ] when the teeth are touching
[ ] reduce the strain in the [ ] *&@ã}Ð[ã •* [ ] when the lips are touching
[ ] make the face more [ ] *¸ãå^Ð æ¦[¸* [ ]
[ ] reduce the [ ] *¸ãåc@Ð˘||}^••* [ ] of the lower jaw behind the mouth
[ ] make teeth centered more to make my face [ ] *˘]]^¦Ð[¸^¦Á[*]
[ ] other:

3. Symptoms

If you want to reduce pain or discomfort where would it be located? Please be specific about the location; circle the right side, left side or both if they apply.

[ ] in front of the ears [ ] *right / left* [ ]
[ ] below the ears [ ] *right / left* [ ]
[ ] above the ears [ ] *right / left* [ ]
[ ] in the ears [ ] *right / left* [ ]
[ ] neck [ ] *right / left* [ ]
[ ] shoulders [ ] *right / left* [ ]
[ ] teeth [ ] *right / left* [ ]
[ ] sinuses
[ ] eyes [ ] *right / left* [ ]
[ ] jaw click [ ] *right / left* [ ]
[ ] jaw pop [ ] *right / left* [ ]
[ ] jaw locking [ ] *right / left* [ ]
[ ] other: [ ] *right /left* [ ]

Signature: ____________________________________ Date: ______________________

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PATIENT DENTAL HISTORY

Name of local dentist patient sees for cavity checkups /restorative dentistry? ______________________________

Has the patient had any severe jaw or face injuries?_______ Explain:______________________________

Has the patient had any injuries to any teeth?___________Explain: ______________________________

Has the patient had a history of thumb sucking or finger sucking?_____Stopped?______________________

Has the patient consulted with an orthodontist previously? ______________________________

Are you satisfied with the prior treatment? ______________________________

Has There Ever Been A History Of:

____ Clenching Teeth ____ Muscular soreness around head and neck ____Jaw Joint Soreness ____Jaw Joint Popping

_____ Grinding Teeth ____ Headaches (more than normal) ______Jaw Joint Clicking _____Ringing in the Ears

Is there any other information that may be helpful?______________________________

Why are you seeking an orthodontic consultation? (What problems require correction?)____________________

Growth Information for Patients Under 16 Years of Age:

Father's Height________________ Mother's Height_________________Was the patient adopted?________

Patient Resembles: Neither Parent________ Mother__________ Father________

Girls: Has she started menstruation? ______ When? ______/______

Boys: Has his voice changed? ______ When? ______/_______

Names and Ages of Brothers and Sisters: ______________________________

Have they had orthodontic treatment?_______Orthodontist's Name?______________________

Question or Concerns

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