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

MEDICAL HISTORY: Patient's Physician _____ City _____

Is patient in good health? ☐ **Yes** ☐ **No**
Does patient have any history of major illness? ☐ **Yes** ☐ **No**
Have tonsils or adenoids been removed? ☐ **Yes** ☐ **No**
Does patient have tendency to : ☐ **Colds** ☐ **Ear Infections** ☐ **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	☐ Y ☐ N	Anemia	☐ Y ☐ N	Prolonged Bleeding	☐ Y ☐ N
Auto Immune Diseases	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Fainting or Dizziness	☐ Y ☐ N
Heart Trouble	☐ Y ☐ N	Asthma	☐ Y ☐ N	Nervous Disorders	☐ Y ☐ N
Rheumatic Fever	☐ Y ☐ N	Kidney Involvement	☐ Y ☐ N	Liver Involvement	☐ Y ☐ N
Bone Disorders	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Arthritis	☐ Y ☐ N
Tuberculosis	☐ Y ☐ N	Endocrine Problems	☐ Y ☐ N	LATEX Allergy	☐ Y ☐ N