BODINE
ORTHODONTICS

ADOLESCENT PATIENT INFORMATION

NAME _____ PREFERRED NAME _____

BIRTHDATE _____ AGE _____ GENDER ☐ MALE ☐ FEMALE

ADDRRESS _____

PHONE (home) _____ (cell) _____

SCHOOL _____ GRADE _____

DENTIST _____DATE OF LAST VISIT _____

SIBLINGS (name/DOB) _____

ADOPTED ☐ YES ☐ NO WHOSE FACIAL/DENTAL STRUCTURE DOES PATIENT RESEMBLE? ☐ FATHER ☐ MOTHER

HAS THE PATIENT EVER HAD AN ORTHODONTIC EVALUATION BEFORE? ☐ YES ☐ NO IF SO, WHERE? _____

PARENT/GUARDIAN INFORMATION

*** If parents are separated/divorced, please circle the name of the person who is financially responsible.***

FATHER ☐ Dr. ☐ Mr.

NAME _____ EMAIL _____

ADDRESS (home) _____# OF YEARS @ ADDRESSS _____

PHONE (home) _____ (work) _____ (cell) _____

EMPLOYER _____ # OF YEARS_____ OCCUPATION _____

BIRTHDATE _____ SSN _____

MOTHER ☐ Dr. ☐ Miss ☐ Ms. ☐ Mrs.

NAME _____ EMAIL _____

ADDRESS (home) _____# OF YEARS @ ADDRESSS _____

PHONE (home) _____ (work) _____ (cell) _____

EMPLOYER _____ # OF YEARS_____ OCCUPATION _____

BIRTHDATE _____ SSN _____

ADDITIONAL INFORMATION

WHAT IS YOUR CHIEF CONCERN? _____

WHOM MAY WE THANK FOR REFERRING YOU TO BODINE ORTHODONTICS? _____

Retention of Documents Relating to Patient Care. By signing this, you understand and agree that is it our policy to scan and store original documents in electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed in electronic form, has the same force and effect as the original document.

NAME _____ **SIGNATURE** _____ **DATE** _____

(OVER)

DENTAL HISTORY

CHECK IF THE PATIENT CURRENTLY HAS OR HAS HAD ANY OF THE FOLLOWING:

☐ Blisters on lips/mouth
☐ Broken fillings
☐ Burning sensation, tongue
☐ Chews on tongue
☐ Dry mouth
☐ Extracted teeth
☐ Finger/thumb habits
☐ Food trapped between teeth
☐ Grinding teeth
☐ Gums bleeding
☐ Gums sore/swollen
☐ Injuries to teeth/jaw
☐ Injuries to face/head
☐ Jaw clicking/popping
☐ Jaw locking open/closed
☐ Jaw pain/tenderness
☐ Jaw surgery
☐ Lip/cheek biting
☐ Loose teeth (other than baby teeth)
☐ Mouth breathing
☐ Mouth pain when brushing
☐ Orthodontic treatment
☐ Pain around ear
☐ Periodontal treatment
☐ Periodontal surgery
☐ Sensitivity to hot or cold
☐ Sensitivity to sweets
☐ Sensitivity to pressure
☐ Sores/growths in mouth
☐ Speech problems
☐ Tongue thrust

HOW OFTEN DOES THE PATIENT BRUSH? _____ FLOSS? _____

ADDITIONAL COMMENTS _____

MEDICAL HISTORY

CHECK IF THE PATIENT CURRENTLY HAS OR HAS HAD ANY OF THE FOLLOWING:

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Artificial heart valves
☐ Artificial joints
☐ Asthma
☐ Back problems
☐ Blood diseases
☐ Bone disorders
☐ Cancer
☐ Chemical dependency
☐ Other (not listed) _____
☐ Chemotherapy
☐ Circulatory problems
☐ Cortisone treatment
☐ Coughing - persistent
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart problems
☐ Hepatitis
☐ High blood pressure
☐ HIV Positive
☐ Kidney disease
☐ Liver disease
☐ Mitral valve prolapse
☐ Nervous system problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation treatment
☐ Respiratory disease
☐ Scarlet fever
☐ Shortness of breath
☐ Stroke
☐ Stomach ulcers
☐ Swelling of feet
☐ Thyroid problems
☐ Tobacco habit
☐ Tonsillitis
☐ Tonsils removed
☐ Tuberculosis
☐ Urinary problems

FEMALES ONLY AGE OF MANARCHE _____ IS IT POSSIBLE THE PATIENT IS PREGNANT? ☐ YES ☐ NO

IS THE PATIENT UNDER THE CARE OF A PHYSICAIN? ☐ YES ☐ NO FOR WHAT CONDITION? _____

PHYSICIAN'S NAME _____ PHONE _____

MEDIACATIONS

Please list **ANY & ALL** medications the patient is currently taking:

_____

_____

ALLERGIES

Please list **ANY & ALL** known allergies you are aware of:

_____

_____

IS THE PATIENT CURRENLY TAKING OR HAS TAKEN ANY BONE DENSITY MEDICATIONS? ☐ YES ☐ NO
(Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosta, Bonefos, Boniva, Didronel, Foasmax, Fosamax+D, Reclast, Skelid, or Zometa)

The above information is accurate and complete to the best of my knowledge and is only for use in my child's treatment. It is my responsibility to inform this office of any changes in my child's personal information or health status. I will not hold Bodine Orthodontics or the staff responsible for any errors or omissions that I have made in the completion of this form

NAME _____ **SIGNATURE** _____ **DATE** _____