

Welcome to Lupi Orthodontics!

Patient Information

Name _____
Birthdate ____/____/____ Last First Middle Nickname
Age ____ Sex ____ School _____
Address _____ Home Phone (____) _____
Family Dentist _____ Whom may we thank for referring you to our office? _____

Responsible Party/Orthodontic Insurance Information

Mother's Name _____
Last First MI
Address _____
Street City State Zipcode
SSN _____ DOB _____ Marital Status _____
How long at this address? _____ rent/own? _____ Email _____ Home Phone () _____
(circle one)
Employed by: _____ Work Phone () _____
How long with this employer?: _____ Cell Phone () _____
Previous employer? _____ How long with this employer? _____
Does Mother have orthodontic insurance? _____ yes _____ no If "Yes", complete below:
Insurance company: _____ Address: _____
Phone # _____ Group # _____ ID # _____

Father's Name _____
Last First MI
Address _____
Street City State Zipcode
SSN _____ DOB _____ Marital Status _____
How long at this address? _____ rent/own? _____ Email _____ Home Phone () _____
(circle one)
Employed by: _____ Work Phone () _____
How long with this employer?: _____ Cell Phone () _____
Previous employer? _____ How long with this employer? _____
Does Father have orthodontic insurance? _____ yes _____ no If "Yes", complete below:
Insurance company: _____ Address: _____
Phone # _____ Group # _____ ID # _____

Medical History

Please answer the following as completely as possible:

Yes No

___ ___ Is the patient currently being treated by a physician? If yes, reason: _____

Physician's name _____ Phone: _____

___ ___ Is the patient currently taking any medication: If yes, describe: _____

___ ___ Is patient allergic to any medications (i.e. penicillin): If yes, list: _____

___ ___ Does patient have any other allergies (i.e. latex, metals)? If yes, _____

___ ___ Is the patient a smoker? If yes, how much? _____ How long? _____

Has the patient had or does the patient have any of the following:

Yes No

___ ___ Rheumatic Fever
___ ___ Heart Murmur
___ ___ Heart Disease
___ ___ High Blood Pressure
___ ___ Bleeding Disorder
___ ___ Diabetes
___ ___ Ulcers
___ ___ AIDS/HIV Infection
___ ___ Hepatitis
___ ___ Herpes (any type)
___ ___ Psoriasis
___ ___ Cancer
___ ___ Asthma
___ ___ Liver Problems
___ ___ Kidney Problems

Yes No

___ ___ Frequent Headaches
___ ___ Migraines
___ ___ Neck Pain
___ ___ Nerve or Brain disease
___ ___ Epilepsy
___ ___ Mental Health Problems
___ ___ Mental Retardation
___ ___ Learning Disabilities
___ ___ Bone Disorders
___ ___ Arthritis (any type)
___ ___ Sleep Apnea
___ ___ Speech/Hearing Problems
___ ___ Frequent Earaches
___ ___ Sinus Infections

Please list any other significant information or comments to include any other serious illness:

Please indicate if the patient was born with any of the following

Yes No

___ ___ Cleft Palate
___ ___ Cleft Lip
___ ___ Other Craniofacial Anomalies

Yes No

___ ___ Anomalies of the Feet
___ ___ Anomalies of the Hands
___ ___ Congenital Heart Defects

Growth History

	Yes	No
Have you noticed a significant growth spurt recently	___	___
Has the shoe size changed twice over the past two years?	___	___
Does the patient's growth rate compare favorably with siblings?	___	___
Do you feel that growth has been completed for the most part?	___	___
For girls, has menarche (onset of menstruation) been reached?	___	___
If so, at what age? _____		

Dental History

Yes No

___ ___ Primary or permanent teeth extractions? If yes, explain: _____

___ ___ A major accident, fall, trauma or operation to the mouth or jaw? If yes, explain: _____

___ ___ A root canal or noted root resorption by their dentist? If yes, explain: _____

___ ___ Treatment for periodontal (gum disease) problems? If yes, describe _____

___ ___ Difficulty breathing through the nose? If yes, explain: _____

___ ___ Tonsil/adenoids removal? If so, at what age: _____

___ ___ Thumb sucking: If yes, is this a current habit? ___ If no, when did it stop? _____

___ ___ Finger sucking? If yes, is this a current habit? ___ If no, when did it stop? _____

___ ___ Lip biting? If yes, is this a current habit? ___ If no, when did it stop? _____

___ ___ Any other oral habits? If yes, describe: _____

___ ___ Teeth clenching or grinding? If yes, while sleeping? ___ under stress? ___ other: _____

___ ___ Pain when chewing? If yes, explain: _____

___ ___ Soreness, stiffness, tightness or pain in the muscles around the jaws and/or face: If yes, describe: _____

___ ___ Clicking, popping or grinding sounds in the jaw joints: If yes, describe: _____

___ ___ Jaw locking open or closed: If yes, describe: _____

How often does the patient brush? _____

Has the patient ever had any kind of orthodontic treatment? If yes, explain: _____

Why did you seek orthodontic treatment? _____

Please explain what you expect as a result of orthodontic treatment: _____

The information contained in this form is accurate and correct to the best of my knowledge.

Parent/Guardian signature

Date