DRS ENSOR JOHNSON & LEWIS

Child & Young Adult Orthodontics

Date:_____

Personal History:

Name:_____Nickname:_____Age:____Date of Birth:_____

Sex:____School:_____Grade:_____Number of Children in the Family:_____

***Already a Dental Patient at EJL*? If so, you may skip filling in the demographic information and continue to the next section.**

Home Address:_____City/State/Zip:_____

Dentist:_____Physician:_____Home Phone:_____

How did you hear about us?_____

Parent's Full Name:_____Cell Phone #:_____Work Phone#:_____

Employer:_____Position:_____

Parent's Full Name:_____Cell Phone #:_____Work Phone#:_____

Employer:_____Position:_____

Parent #1's Email:_____Parent #2's Email:_____

Do you have Orthodontic Insurance? Yes___No___If Yes, Name of Insurance Carrier:_____

Has the patient ever had any orthodontic consultation or treatment? Yes___No____

If Yes, please describe:_____

Names/Relationships of any family members that have received orthodontic care:_____

_____

Is patient living with both parents? Yes_____No____If No, with whom is patient living?_____

Brothers' Ages:_____Sisters' Ages:_____Musical Instruments Played:_____

Sports/Hobbies:_____

Medical Health History:

Please check any of the following for which the patient has been treated and comment if necessary:

___Adenoids	___Anemia	___Anxiety	___Arthritis	___Asthma	___Bone Disorders
___Depression	___Diabetes	___Endocrine Disorders	___Epilepsy	___Fainting or Dizziness	___Hepatitis
___Poor Health	___Prolonged Bleeding	___Rheumatic Fever	___Tuberculosis	___Other	

If Other, please explain:_____

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Does the patient have a tendency to colds? Yes__No__ Sore throats? Yes___No___ Ear Infections? Yes__No___
Weight_____lbs Height_____Allergies:_____
Have Tonsils or Adenoids been removed? Yes_____No_____If Yes, at what age?_____
Any broken bones? Yes____No_____ If Yes, did they heal satisfactorily? Yes____No____
Any Psychological counseling? Yes__No___ Has the patient reached puberty? Yes____No_____
Girls: Has she started menstruation? Yes____No____ Boys: Has his voice changed? Yes___No_
Has the patient ever had any reaction to a drug or medication? Yes__No___If Yes, please describe below: _____

_____

To the best of your knowledge, is the patient in good health? Yes__No___
If the patient is under the care of a physician for any condition or is taking any medications, please explain and list: _____

_____

Dental History:

Has the patient had any injuries to the face? Yes____No____ Mouth or teeth? Yes__No__
Has the patient ever sucked a thumb or fingers? Yes__No__Until what age?_____
Does the patient have any speech issues?_____
Is the patient a mouth breather?_____ While asleep?_____ While awake?_____
Does the patient grind his/her teeth? Yes____No____ Bite his/her lip? Yes__No__
Have you ever been informed of any missing or extra permanent teeth?_____
How often does the patient brush his/her teeth?_____
Any pain in or near the ears? Yes___No_____ Right____Left____Both_____
Any clicking or discomfort in the jaw joint near the ears? Yes___No_____ Right____Left____Both_____
In your own words, what would you like us to accomplish? _____

_____

Parent or Guardian Name:_____

Parent or Guardian Signature:_____