

PATIENT INFORMATION – UNDER 18 YEARS OF AGE

J. Thomas Hedrick, D.D.S., M.S.D.

Aleco E. Tujios, D.D.S, M.S.

Jeffrey G. Johnson, D.D.S, M.S.

WOODHILL DENTAL SPECIALTIES - SPECIALISTS IN PEDIATRIC DENTISTRY & ORTHODONTICS
8355 WALNUT HILL LANE, SUITE 100, DALLAS, TEXAS 75231 PHONE: 214-691-1172 FAX: 214-239-8597

PERSONAL HISTORY

CHILD'S FULL LEGAL NAME		PREFERRED NAME		
BIRTHDATE	AGE	HEIGHT	WEIGHT	SEX
STREET		CITY	STATE	ZIP
MAIN CONTACT TELEPHONE NUMBER		MAIN CONTACT EMAIL ADDRESS		
SCHOOL		SCHOOL DISTRICT		GRADE
FULL NAME OF RESPONSIBLE PARTY		RELATIONSHIP TO PATIENT		
CELL PHONE NUMBER OF RESPONSIBLE PARTY		OCCUPATION OF RESPONSIBLE PARTY		
MARITAL STATUS (PLEASE CHECK ONE): <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED				
ADDRESS IF DIFFERENT FROM ABOVE				
SPOUSE'S / SIGNIFICANT-OTHER'S FULL NAME		RELATIONSHIP TO PATIENT		
CELL PHONE NUMBER		OCCUPATION		
ADDRESS IF DIFFERENT FROM ABOVE				
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE		

SOCIAL HISTORY

HOW, OR FROM WHOM DID YOU LEARN ABOUT OUR PRACTICE?
HAVE WE SEEN YOU OR ANYONE ELSE IN YOUR FAMILY IN OUR OFFICE BEFORE? IF SO, PLEASE TELL US WHO.
YOUR CHILD'S FAVORITE PLAYMATE, PET, TOY, HOBBY, OR SPORT

DENTAL INSURANCE

NAME OF POLICYHOLDER (INSURED)	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NUMBER
EMPLOYER	EMPLOYER'S PHONE	
INSURANCE COMPANY'S NAME	INSURANCE COMPANY'S PHONE	
INSURANCE COMPANY'S ADDRESS	GROUP NUMBER	MEMBER ID NUMBER

MEDICAL HISTORY

PHYSICIAN'S NAME	DATE OF LAST VISIT
ADDRESS	PHONE

PLEASE CHECK YES OR NO (IF YES, PLEASE FILL IN DETAILS)

<input type="checkbox"/> YES	<input type="checkbox"/> NO	Is the patient taking any medication?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Is the patient allergic to any medication?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	History of a major illness?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Has the patient had any operations?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ever been involved in a serious accident
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Seen a physician in the last 12 months? Why?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Female patients only: Has menstruation started?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Female patients only: Is the patient pregnant?

CHECK ANY MEDICAL CONDITIONS BELOW THAT THE PATIENT HAS HAD OR CURRENTLY HAS

<input type="checkbox"/> Abnormal bleeding/Hemophilia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis/Liver Problems	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Herpes	<input type="checkbox"/> Prolonged Bleeding
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Radiation/Chemotherapy
<input type="checkbox"/> Asthma or Hayfever	<input type="checkbox"/> Gastrointestinal Disorders	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Tumor or Cancer
ARE THERE ANY MEDICAL CONDITIONS WE HAVE NOT DISCUSSED THAT YOU FEEL WE SHOULD BE AWARE OF?			

DENTAL HISTORY

GENERAL DENTIST'S FIRST /LAST NAME	DATE OF LAST VISIT
ADDRESS	PHONE
WHAT CONCERNS YOU MOST ABOUT YOUR TEETH?	

<input type="checkbox"/> YES	<input type="checkbox"/> NO	Is the patient presently in any dental pain?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ever experienced any unfavorable reaction to dentistry?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Has the patient ever lost or chipped any teeth?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have there been any injuries to face, mouth or teeth?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Is any part of your mouth sensitive to temperature? Where?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Is any part of your mouth sensitive to pressure? Where?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do gums bleed when brushing?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Any type of thumb or tongue habit?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Is the patient a mouth-breather?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Has the patient ever seen an orthodontist? If yes, who and when?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Has anyone in the family received orthodontic treatment?
How did they feel about the result?		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do teeth or jaws ever feel uncomfortable first thing in the morning?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Experience jaw clicking or popping?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Aware of clenching or grinding teeth during the day?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Experience "tension" headaches?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Has the patient ever experienced chronic ringing in the ears?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	Does the patient need extra help with instructions?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Is the patient sensitive or self-conscious about his/her teeth?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Are you aware that some appointments will be during school hours?
What is the patient's attitude toward receiving orthodontic treatment?		

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph.

I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. _____ to perform a complete orthodontic evaluation.

Signature: _____ Date: _____