Patient Information (Minor)

Patient Name ____/____________________

First Middle Last Nickname

D.O.B. ____________ Age _______ Gender M ☐ F ☐ SSN ________- ________- __________

Address ____

City ______________________________ State _________________Zip/Postal Code___________

Home Phone Number ( ) ___________ Patient E-mail Address__________________________

General Dentist __________________________ Date Last Seen _________________________

Who may we thank for referring you? ____

Hobbies/Interests ____

Attends School At____

Number of siblings____________ Siblings names______________________________________

Responsible Party / Guardian / Parent Information

Mother's Name_____________________________ D.O.B_________ SS#__________________

Address (if different than patient's) ____

City ______________________________ State _________________Zip/Postal Code___________

Phone Numbers Home ( )_____________ Cell ( )_____________Work ( )____________

Place of Employment___________________________________ Occupation_________________

Dental Insurance Company_______________________________________ Group#_____________

Dad's Name_______________________________ D.O.B_________ SS#__________________

Address (if different than patient's) ____

City ______________________________ State _________________Zip/Postal Code___________

Phone Numbers Home ( )_____________ Cell ( )_____________Work ( )____________

Place of Employment___________________________________ Occupation_________________

Dental Insurance Company_______________________________________ Group#_____________

Emergency Information

Name of person to contact in case of emergency ___________________________________

Address ____

Phone ( ) _________________ Relationship_______________________________________

Segal and Iyer Orthodontics

Dental and Health History

Name ______________________________ D.O.B. ____________ Gender M ☐ F ☐

First Middle Last

Dental Orthodontic History	Yes	No	Additional Information
Thumb/ Finger sucking			
Tongue thrust			
Clenching/ grinding teeth			
Mouth breathing habit, snoring or difficulty in breathing			
Chipped or otherwise injured primary (baby) or permanent teeth			
Difficulty in chewing or jaw opening			
Had periodontal (gum) treatment			
Teeth sensitive to hot or cold			
Speech problems			
Supernumerary (extra) or congenitally missing teeth			
Had prior orthodontic examination or treatment			
Bleeding gums, bad taste or mouth odor			
Periodontal “gum problems”			
Any pain or soreness in the muscles of the face or around the ears			
Aware of any loose, broken or missing restorations (fillings)			
Taking any forms of fluoride			
Suffered injuries to your face, mouth, teeth or chin			

Medical History	Yes	No
Abnormal bleeding		
ADD/ ADHD		
AIDS/ HIV+		
Any operation		
Artificial Joints/ Valves		
Asthma		
Cancer		
Congenital Heart Disorder		
Convulsions		
Diabetes		
Epilepsy		
Handicaps/ Disabilities		
Heart Murmur		
Hemophilia		
Hepatitis		
Kidney Problems		
Liver Problems		
Mitral Valve Prolapse		
Prosthetics		
Rheumatic Fever		
Scarlet Fever		
Sickle Cell Disease		
Tuberculosis (TB)		

Medical History

Primary Physician ______________________________

Phone Number (   ) ______________________________

Last Visit ______________________________

Current physical health is: ☐ Good ☐ Fair ☐ Poor

Explain ______________________________

List current medications______________________________

____

Is pre-med required for dental visits? ☐ no ☐ yes

Explain ______________________________

Allergies to medications: ☐ no ☐ yes

Explain______________________________

Other allergies: ☐ yes ☐ no ☐ latex ☐ metals ☐ nickel ☐ plastic

☐ other______________________________

Authorization

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. It is my responsibility to inform Segal and Iyer Orthodontics of changes in my child’s or my own medical status. I authorize the orthodontic staff to perform the necessary dental and/or orthodontic services on my child (if applicable) or myself as needed.

______________________________ ____________

Patient Signature Date