Segal and Iyer Orthodontics

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_____

Parent(s) / Responsible Party

Parent'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#_____

Parent'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

The information I have provided is correct to the best of my knowledge. I understand that it is my responsibility to inform Segal and Iyer Orthodontics of changes in my child's medical status. I authorize the orthodontic staff to perform the necessary dental and/or orthodontic services on my child as needed.

_____ _____

Parent's Signature Date