RESLER ORTHODONTICS
PATIENT INFORMATION CARD

DATE______________________

DATE OF BIRTH______________________

Patient's Name______________________ Age______ Sex______ Phone______________

Res. Address______________________ City______________ Zip__________

SCHOOL______________________ GRADE__________

Patient's Dentist______________________ Oral Surgeon______________________

Physician______________________ Referred By______________________

FATHER'S NAME______________________ Occupation ______________________

Employed by______________________ Bus. Telephone______________________

Home Address______________________

MOTHER'S NAME______________________ Occupation ______________________

Employed by______________________ Bus. Telephone______________________

Home Address______________________

MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorders
- ❑ Bones/joints
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Chronic Sinusitis
- ❑ Currently Pregnant
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Growth Problems
- ❑ Hearing
- ❑ Heart
- ❑ Hepatitis
- ❑ HIV+/AIDS
- ❑ Kidney
- ❑ Latex Allergy
- ❑ Liver
- ❑ Osteoporosis
- ❑ Rheumatic fever
- ❑ Seizures
- ❑ Sickle Cell
- ❑ Thyroid
- ❑ Tobacco/Drug Use
- ❑ Tuberculosis
- ❑ Venereal Disease
- ❑ Other__________

____

Are there any medical conditions we have not discussed that you feel we should be aware of? ______________________

____

Have tonsils and adenoids been removed? Yes ❑ No ❑ What age?______________

List all medications taken ______________________

DENTAL HISTORY

What concerns you most about your teeth? ______________________

Reason for consultation?______________________

Have you ever lost or chipped any teeth?______________________ Yes ❑ No ❑

Have there been any injuries to the face, mouth, or teeth?______________________ Yes ❑ No ❑

Have you been informed of any extra or missing permanent teeth?______________________ Yes ❑ No ❑

Do your gums bleed when you brush?______________________ Yes ❑ No ❑

Have you ever sucked your thumb or fingers? Until what age?______________________ Yes ❑ No ❑

Are you a mouth breather?______________________ Yes ❑ No ❑

Have you ever seen an orthodontist?______________________ Yes ❑ No ❑

Has anyone in the family received orthodontic treatment?______________________ Yes ❑ No ❑

Do your teeth or jaws ever feel uncomfortable when you wake in the morning?______________________ Yes ❑ No ❑

Are you aware of your jaw clicking or popping?______________________ Yes ❑ No ❑

Are you aware of clenching your teeth? ______________________ Yes ❑ No ❑

Have you been told you grind your teeth?______________________ Yes ❑ No ❑

Name____ Age__________

DENTAL HISTORY CONTINUED

Have you ever worn a splint or bite guard?______________________________ Yes ❑ No ❑

Do you have "tension" headaches?______________________________ Yes ❑ No ❑

Have you ever experienced chronic ringing in your ears?______________________________ Yes ❑ No ❑

Do you have any speech problems?______________________________ Yes ❑ No ❑

List any musical instruments played:______________________________

Are you aware that some appointments will be during school/work hours?__________ Yes ❑ No ❑

Names and ages of other children in the family ______________________________

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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 the general dental health. Teeth, gums and jaws are an intricate body part 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 the above paragraph. I also understand that my diagnostic records may be used for educational purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

______________________________ Parent Signature   ______________ Date

I hereby authorize Resler Orthodontics to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

______________________________ Parent Signature   ______________ Social Security #   ______________ Date

DATE		FEE	DATE		FEE

RECOMMENDATIONS:

DATE		FEE