LakePointe Orthodontics
Patient Friendly...Committed to Excellence

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GET ACQUAINTED QUESTIONNAIRE
FOR PATIENT'S UNDER 18 YEARS OF AGE

The following information is needed to enable us to give you the most consideration and best service possible. This information is, of course, confidential. Thank you.

Patient's full name _____ Date of Birth _____ Age _____ Phone _____
Address _____ City _____ State _____ Zip _____
Email Address _____ Cell Phone _____
Family Dentist _____ City _____ Phone _____ Last Visit: _____
Family Physician _____ City _____ Phone _____
School _____ Grade _____ Name patient likes to be called _____
Sports, Hobbies, etc. _____ Musical instrument played _____
Parents' Full Names _____ Siblings (names.ages) _____
Parents: Married _____ Separated _____ Divorced _____ Widowed _____ Single _____
Siblings having had orthodontic treatment: _____
Major reason for seeking orthodontic treatment: _____
How did you hear about our office? _____

DENTAL HISTORY

	NO	UNSURE	YES	
Has there been a thumb or finger habit?	☐	☐	☐	notes: _____
Have there been any injuries to the face, mouth or teeth?	☐	☐	☐	notes: _____
Are you aware of any missing or extra permanent teeth?	☐	☐	☐	notes: _____
Has the patient had any speech problems or therapy?	☐	☐	☐	notes: _____
Does the patient:				
• clench or grind his/her teeth?	☐	☐	☐	notes: _____
• brush his/her teeth conscientiously?	☐	☐	☐	notes: _____
Does the patient have:				
• a history of periodontal (gum) problems?	☐	☐	☐	notes: _____
• a problem with frequent cold/canker sores?	☐	☐	☐	notes: _____
• any difficulty opening his/her mouth?	☐	☐	☐	notes: _____
• any clicking or discomfort in jaw joints near ears?	☐	☐	☐	notes: _____
• headaches or neckaches regularly?	☐	☐	☐	notes: _____
• pain in the jaw joints while eating?	☐	☐	☐	notes: _____
• any congenital abnormalities? (cleft palate, etc.)	☐	☐	☐	notes: _____

ATTITUDE TOWARD TREATMENT

Is the patient aware of spaced, crooked or protruding teeth? ☐ No ☐ Yes Concerned? ☐ No ☐ Yes
Do you feel that it is becoming ☐ Better ☐ Worse ☐ Staying the Same
What would you most like to have orthodontic treatment accomplish? _____
Would the patient object to wearing orthodontic appliances (braces) should they be indicated? ☐ No ☐ Yes
Are you aware that some appointments will infringe upon school/work time? ☐ No ☐ Yes
Has the patient had any previous orthodontic examinations? ☐ No ☐ Yes.. Doctor: _____ Date: _____
Previous Orthodontic Treatment? _____ Describe: _____

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

Please check no or yes to the following and indicate the year:

	No	Yes	Years		No	Yes	Years
Attention Deficit Disorder	____	____	____	Hay Fever	____	____	____
Allergies	____	____	____	Healing Disorder	____	____	____
Anemia or Bleeding Problems	____	____	____	Headaches	____	____	____
Arthritis	____	____	____	Hearing Disorder	____	____	____
Asthma	____	____	____	Heart Disorders (murmur, etc.)	____	____	____
Behavioral Problems	____	____	____	Hepatitis or Liver Disorders	____	____	____
Bone or Joint Disorder	____	____	____	HIV Positive	____	____	____
Breathing or Nasal Disorder	____	____	____	Kidney or Bladder Condition	____	____	____
Diabetes	____	____	____	Mononucleosis	____	____	____
Earaches	____	____	____	Nervous Disorders	____	____	____
Epilepsy or Convulsions	____	____	____	Psychiatric Treatment	____	____	____
Fainting or Dizziness	____	____	____	Psychological Disorder	____	____	____
Gagging or Nausea Problems	____	____	____	Rheumatic Fever	____	____	____
Growth or Endocrine Condition	____	____	____				

General health: Good_____Fair_____Poor_____Birth Defects_____
Presently under medical care for_____
Drugs or medication being taken now (drug and dose)_____
Allergic to any medication_____
Does the patient require antibiotic premedication prior to dental appointments?..... ☐ No.... ☐ Yes
Is the patient a mouth breather?..... ☐ No..... ☐ Yes..... ☐ While asleep..... ☐ While awake
Have tonsils and adenoids been removed?..... ☐ No..... ☐ Yes..... At what age?_____
Does the patient snore at night?..... ☐ No..... ☐ Yes
Growth in the past 6 months: _____
Has the patient reached puberty?..... ☐ No..... ☐ Yes

Height:..... Patient's _____ Mother's _____ Father's _____

RESPONSIBLE PARTY INFORMATION

Name_____
Residence _____
Mailing Address _____
How long at this address _____ Home Phone _____ Work Phone _____
Previous Address (if less than 3 yrs) _____ Zip
Social Security #_____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed_____
Spouse's Name _____ Relationship to Patient _____
Spouse's Address _____
Employer _____ Occupation _____ No. Years Employed _____
Social Security # _____ Birthdate _____ Work Phone _____
Name of nearest relative not living with you _____
Home Phone Work Phone

ORTHODONTIC INSURANCE INFORMATION

Insurance Company _____ Group No. _____ Local No._____
Insurance Co. Address _____
Insured's Name _____ Insured's Soc. Sec. # _____
Insured's Employer _____
Do you have dual coverage? ☐ No ☐ Yes If Yes:
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Insured's Name _____ Insured's Soc. Sec. # _____
Insured's Employer _____

Signature of parent or guardian _____ Date _____
I give permission for patient records to be used for research/educational purposes. _____ Initials
I give permission for pictures of my child to be used on our website or social network. Initials