

Becker & Scott, DDS, LLC
Exceptional Orthodontics for Children & Adults

Date _____

Patient's Name _____
Last First Middle Nickname

Address _____
Street City Zip Phone

How long at current address? _____ Previous address (if less than 3 years) _____
Street City Zip

Birthdate _____ Age _____ Sex _____ School _____ Grade _____

Father's Name _____ Occupation _____ SS# _____

Employer _____ Number of years employed _____ Bus. Phone _____

Business Address _____

Mother's Name _____ Occupation _____ SS# _____

Employer _____ Number of years employed _____ Bus. Phone _____

Business Address _____

Widowed Divorced Person responsible for account _____ Phone _____

Father's Mobile Phone _____ Mother's Mobile Phone _____

E-mail Address _____ Orthodontic Insurance? _____ Insurance Company _____

Names and ages of other children in family _____

Family Dentist _____ Physician _____ Oral Surgeon _____

Referred By _____ May we thank anyone else? _____

GENERAL HEALTH/MEDICAL HISTORY

How would you rate patient's overall health? _____ Does patient have any history of major illness? _____

Check any of the following for which the patient has been treated:

- | | | | | |
|--|---------------------------------------|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Immune deficiency |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Kidney involvement | <input type="checkbox"/> Blood disorder |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Liver involvement | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nervous disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Excessive nervousness |

Have tonsils and adenoids been removed? _____ Age _____

Does patient have tendency for: Colds Sore throats Ear infections Sinus problems

List any allergies or drug sensitivity _____

DENTAL HISTORY

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

Has patient ever sucked a thumb or fingers? Until what age?..... Yes No

Does the patient have any speech problems?..... Yes No

Is the patient a mouth breather while asleep?..... Yes No

Is the patient a mouth breather while awake?..... Yes No

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

Has an orthodontist been consulted previously?..... Yes No

Has either parent had orthodontic treatment?..... Yes No

Does patient get many headaches?..... Yes No

History of arthritis in family?..... Yes No

Does patient have good posture?..... Yes No

List any musical instruments and/or sports played _____

Height _____ Weight _____

Reason for consultation: _____

The policy in our office is: The parent who requests treatment for the child is responsible for all fees for services rendered. I understand that where appropriate, credit bureau reports may be obtained. I authorize the release of all X-rays related to the above named patient.

Parent's Signature _____ Date _____