

Welcome to the office of...

Petrol Orthodontics

Creating beautiful healthy smiles that last a lifetime!

Our entire staff is dedicated to providing the highest quality orthodontic treatment to you and your family in a pleasant environment. Please help us to help you by completing the front and back of these forms. Thank you.

PATIENT INFORMATION CHILD

Date

Patient's Name E-mail

Address City State Zip

Home Phone Birthdate Social Security #

Names & ages of other children at home

Whom may we thank for referring you to our office?

RESPONSIBLE PARTY INFORMATION

Name Marital Status

Residence City State ZIP

Mailing Address City State ZIP

How long at this address Home Phone Work Phone

Previous Adrs (If less than 3 yrs) City State ZIP

Social Security # Birthdate Relationship to Patient

Employer Occupation No. of Years Employed

Spouse's Name

Employer Occupation No. of Years Employed

Social Security # Birthdate Work Phone

INSURANCE INFORMATION

Insured's Name Insured's Soc. Sec.#

Insurance Co. Group # Local #

Insurance Co. Adrs. Phone

Do you have dual coverage? Yes No If "Yes":

Insured's Name Insured's Soc. Sec.#

Insurance Co. Group # Local#

Insurance Co. Adrs Phone

Insured's Employer

Updates (date & initial) _____ / _____ / _____ / _____ / _____ / _____



Patient's Name Nickname Age Sex

Your physician When last visited.....

Your dentist When last visited.....

- Is your child in good health?
Is he or she receiving medical care?
Has your child ever had a serious illness?
Has anyone in your family had diabetes?
Has your child ever been hospitalized?

Have adenoids or tonsils been removed?
If so, at what age

List all prescription and non-prescription drugs or medications taken in the last 3 months (give reasons):

List allergies/sensitivities: Aspirin, Codeine, Sulfa drugs, Novocain, Penicillin, etc.

Please check those items which your child has or is now being treated for:

- Arthritis or joint disease
Asthma or Hayfever
Blood or bleeding disorders
Drug use
Epilepsy or seizures
Fainting or dizziness
Eye problems
Neurological problems
Ulcer or stomach problems
Heart murmur or disease
Kidney or bladder
Hepatitis, jaundice or liver
Skin disorders
Respiratory disorders
Rheumatic or Scarlet fever
Tuberculosis
Nervousness
Sexually transmitted diseases
Has your child ever been tested for AIDS, HIV or ARC
Endocrine problems
Diabetes
Emotional problems
Other illnesses:

Does the patient have any of the following habits:

- Finger or thumb sucking
Mouth breathing
Tongue thrust (abnormal swallowing)
Clenching or grinding teeth
Other oral habits

- Have there ever been any injuries to the face, mouth or teeth?
Does your child brush his or her teeth 3 times a day?
Does he or she floss daily?
Does your child have any missing or extra permanent teeth?
Has your child ever noticed pain or clicking in the jaw joint?
Has your child's jaw ever locked open or closed?

ORTHODONTIC HISTORY

- What would you like to change about his or her appearance?
Are you pleased with their facial profile?
Has the patient had past orthodontic treatment, and by whom?
Has any family member had orthodontic treatment?
Does anyone in the family have a similar dental condition?

What would you like orthodontic treatment to accomplish?

Name of the nearest relative not living with you Emergency Phone#

Signature Date

Updates (date & initial) / / / / /