



RONALD C. PERKINS, DDS, MSD
ORTHODONTIC ACQUAINTANCE

Date _____ Date of Birth _____

Patient's Name _____ Age _____ Sex _____
Last First Initial

Res. Address _____

Phone _____ City _____ State _____ Zipcode _____
Directions (If P.O. Box or Rural Route) _____

School _____ Grade _____ Interests _____

How did you first hear about our office? _____

Patient's Dentist _____ Physician _____

Patient's Oral Surgeon _____

Father's Name _____ Occupation _____

Married _____ Separated _____ Divorced _____

Employed By _____ Business Phone _____

O.K. to contact at work? Yes No

Bus. Address _____ Soc. Sec. No. _____

Home Address _____

Does Father Have Orthodontic Insurance? Yes No Group # _____ Group Name _____

Mother's Name _____ Occupation _____

Married _____ Separated _____ Divorced _____

Employed By _____ Business Phone _____

O.K. to contact at work? Yes No

Business Address _____ Soc. Sec. No. _____

Home Address _____

Does Mother Have Orthodontic Insurance? Yes No Group # _____ Group Name _____

Person financially responsible for fees: Name _____

Address/Phone _____ Relationship _____

Names and ages of other children in family _____

Do you anticipate a move or transfer in the near future? Yes No

MEDICAL HISTORY

(Check any of the following for which patient has been treated)

- | | | |
|---|--|---|
| Diabetes..... <input type="checkbox"/> | Anemia..... <input type="checkbox"/> | Prolonged Bleeding..... <input type="checkbox"/> |
| Pneumonia..... <input type="checkbox"/> | Epilepsy..... <input type="checkbox"/> | Fainting or Dizziness..... <input type="checkbox"/> |
| Heart Trouble..... <input type="checkbox"/> | Asthma..... <input type="checkbox"/> | Nervous disorders..... <input type="checkbox"/> |
| Rheumatic Fever..... <input type="checkbox"/> | Kidney Involvement... <input type="checkbox"/> | Hepatitis..... <input type="checkbox"/> |
| Bone Disorders..... <input type="checkbox"/> | Tuberculosis..... <input type="checkbox"/> | Endocrine Problems..... <input type="checkbox"/> |
| | | Others..... <input type="checkbox"/> |

Does the patient have any diseases we should be aware of? _____ Yes No

Is patient in good health? _____ Yes No

Does patient have any history of major illness? _____ Yes No

Please list _____

Does patient have tendency to colds? Sore throats? Ear infections?

Have tonsils and adenoids been removed? What age? _____ Yes No

List any drugs or medications now being taken. Give reasons: _____

List any allergies or drug sensitivity _____

Date of last visit to the M.D. _____ Physical Exam _____

Height _____ Weight _____ Contact Lenses Yes No

Problems of the jaw - Have you ever experienced:

- a) Clicking of the jaw? _____ Yes No
- b) Pain (joint, ear, side of face)? _____ Yes No
- c) Difficulty in opening and closing? _____ Yes No
- d) Difficulty in chewing? _____ Yes No
- e) Ringing in the ears? _____ Yes No
- f) Jaw locking? _____ Yes No

Habits - Do you:

- a) Bite your fingernails? _____ Yes No
- b) Clench or grind your teeth while awake or asleep? _____ Yes No
- c) Bite your lips or cheeks regularly? _____ Yes No
- d) Hold foreign objects with the teeth (such as pencils, pipe, nails) _____ Yes No

Do you have headaches? _____ Yes No

How frequent? _____ Location _____

DENTAL HISTORY

Has there been any injuries to the face, mouth or teeth? _____ Yes No

Has the 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 awake _____ Yes No

While asleep? _____ 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

What is the patient's main concern for today's visit? _____

Has the patient reached puberty - Girls - has she started menstruation? _____ Yes No

- Boys - has his voice changed? _____ Yes No

Is patient adopted? Yes No Does patient know? Yes No

Are there any learning disabilities? Yes No If yes, explain _____

Has the patient ever been exposed to any of the following:

Herpes.....Yes No ; Aids.....Yes No ; Venereal Diseases.....Yes No

I authorize Dr. Perkins to use Nitrous Oxide if necessary to aid with discomfort...Yes No

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to the history record, I will so inform this practice. I also authorize Dr. Ronald C. Perkins to perform an orthodontic examination.

Signature (Patient/Responsible Adult)

Date

This information has been reviewed with the above named individual.

Signature

Position

Date