WELCOME TO TYSONS WEST ORTHODONTICS & CHILDREN'S DENTISTRY

Date _____

Patient Name _____

Sex ( ) M ( ) F Age _____ *DOB* ___/ ___/_____

SSN _ _ _ - _ _ - _ _ _ _

Parent's/Guardian's Name _____

Relationship to Patient _____

( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced

Address _____

*City*_____ *State* _____ *Zip* _____

Home Phone Number _____

Primary Cell 1 _____

*Secondary Cell 2*_____

(Primary)

Policy Holder _____

Date of Birth _____

Relationship to Patient _____

Insurance Co _____

Insurance Co Phone # _____

Policy/ID # _____ *Group #* _____

(Secondary)

Policy Holder _____

Date of Birth _____

Relationship to Patient _____

Insurance Co _____

Insurance Co Phone # _____

Policy/ID # _____ *Group #*

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental Xrays _____

- *Clicking or popping of the jaw*
- *Dry Mouth*
- *Fingernail biting*
- *Thumbsucking*
- *Grinding teeth*
- *Swollen and tender gums*
- *Loose teeth or broken fillings*
- *Mouth breathing*
- *Orthodontic treatment*
- *Teeth Sensitivity*
- *Mouth sores, fever blisters*

Physician Name _____

_____

Physician Address _____

_____

Date of Last Visit

Physician Phone #

- *ADD/ADHD*
- *Aids*
- *Anemia, sickle cell*
- *Artificial Heart Valves*
- *Artificial joints*
- *Autism spectrum disorder*
- *Asthma*
- *Abnormal Bleeding*
- *Blood Disorders*
- *Headaches, Migraines*
- *Heart Murmur, heart defects*
- *Hepatitis Type*
- *Herpes*
- *High Blood Pressure*
- *HIV Positive*
- *Impaired vision, hearing or speech*
- *Hydrocephaly or placement of a shunt*
- -
- *Radiation Treatment*
- *Respiratory Disease*
- *Rheumatic Fever*
- *Sleep apnea/snoring, mouthbreathing*
- *Shortness of Breath*
- *Sinusitis*
- *Rash/hives, eczema*
- *Special Diet*
- *Stroke*
- *Thyroid Problems*
- *Tonsillitis*
- *Tumor or growth on neck*

Provide details here

MEDICATIONS

List medications you are currently taking

_____

_____

_____

Pharmacy Name _____

Phone Number _____

Place a mark to indicate if you have any of the

- *Penicillin*
- *Sulfa*
- *Latex*
- *Food Allergies*
- PROVIDE DETAILS HERE:

QUESTIONS FOR ADOLESCENT PATIENTS (12-20)

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER:

Was your child born prematurely? ❑ YES ❑ NO If YES, what week?

What was your child's birth weight? _____

How long was your child breast-fed? ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

How long was your child bottle-fed? ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

Do/did you feed your child infant formula? ❑ YES ❑ NO If YES, what type? (check one): ❑ Ready to use ❑ Powdered ❑ Liquid concentrate

Does/did your child sleep with a bottle? ❑ YES ❑ NO If YES, content of bottle? _____

Does/did your child use a no-spill training cup (sippy cup)? ❑ YES ❑ NO

Child's age (in months) when first tooth appeared in mouth

Has your child experienced any teething problems? ❑ YES ❑ NO

When did you begin brushing his/her teeth? ❑ N/A ❑ before age 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 yrs

When did you begin using toothpaste? ❑ N/A ❑ before age 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 yrs

Who is your child's primary care minder during the day? _____ during the evenings? _____

Name/age of siblings at home: _____

_____

Signature of parent/guardian Relationship to child Date Signature of staff member reviewing history

Females: Are you pregnant or possibly pregnant? ❑ YES ❑ NO

Is there anything you would like to discuss confidentially with your dentist? ❑ YES ❑ NO

Would you like to discuss a referral to a family dentist or general dentist because of your age? ❑ YES ❑ NO

Signature of patient Date Signature of staff member reviewing history