BALTIMORE ORTHODONTIC GROUP

PRACTICE LIMITED TO ORTHODONTICS

This initial consultation appointment is to determine whether or not orthodontic treatment is needed, at what age level it would be most advantageous, and to give you some insight into orthodontic treatment.

If orthodontic treatment is recommended, this appointment may also be for the purpose of taking diagnostic records consisting of X-rays, photographs and study models. These "diagnostic aids," become the textbook of your child's case. A second appointment is scheduled to confer with the parents of the child or with the adult patient. At this conference appointment all aspects of treatment are thoroughly discussed.

If treatment is not indicated at this time, periodic observation appointments may be necessary to assess the proper timing for treatment.

PATIENT INFORMATION

Date _____

Patient's Name _____
FIRST MIDDLE LAST PREF. NAME

Home Address _____
STREET CITY STATE ZIP

Home Phone _____ Birthdate _____

If patient is a minor, give parent's or guardian's name _____ Sex: ☐ M ☐ F

Friends or relatives in treatment _____

Name and age of siblings _____

RESPONSIBLE PARTY INFORMATION

Name _____
FIRST MIDDLE LAST MARITAL STATUS

Home Address _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

E-mail Address: _____ Employer _____

Spouse's Name _____
FIRST MIDDLE LAST

Social Security # _____ Birthdate _____ Relationship to Patient _____

E-mail Address: _____ Employer _____

DENTAL INFORMATION

Family Dentist _____

Address _____
STREET CITY STATE ZIP

Date of last dental check up _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Insured's Name _____ Insured's ID # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____
STREET CITY STATE ZIP

Insured's Employer _____

Signature (Parent's signature if minor) _____

Patient Name _____ Date _____

Family Dentist _____ Physician _____

MEDICAL HISTORY

YES	NO	
☐	☐	Date of last physical examination _____
☐	☐	Are you currently under treatment for a physical or emotional problem?
☐	☐	Has there been any change in your general health or weight during the past year?
☐	☐	Are you taking any drugs or medication (including oral contraceptives or hyperkenetic drugs)?
☐	☐	Are you allergic to any drugs (including aspirin, penicillin or codeine)?
☐	☐	Have you been hospitalized for any operations or radiation treatment?
☐	☐	Have you ever had a serious accident involving head injuries?

DO YOU HAVE OR HAVE YOU HAD, ANY OF THE FOLLOWING:

☐	☐	Fainting spells, epilepsy or stroke?
☐	☐	Emotional problems or psychiatric care, alcoholism or drug addiction?
☐	☐	Glaucoma, or other eye disorders?
☐	☐	Sinus trouble, tonsilitis, sore throat, or ear infection?
☐	☐	Allergies, asthma, or hay fever?
☐	☐	Thyroid or endocrine problems?
☐	☐	Rheumatic fever or rheumatic heart diseases?
☐	☐	Congenital heart defects?
☐	☐	Cardiovascular disease (heart attack, high / low blood pressure)?
☐	☐	Blood disorder, anemia or bleeding problems?
☐	☐	Respiratory disease, pneumonia, tuberculosis, shortness of breath?
☐	☐	Diabetes?
☐	☐	Liver disease, heptitis or jaundice?
☐	☐	Kidney disease?
☐	☐	Ulcers, stomach, intestinal or bowel problems?
☐	☐	Venereal disease?
☐	☐	X-ray or chemo-therapy for a tumor?
☐	☐	Physical handicaps, mental retardation?
☐	☐	Have you reached puberty?
☐	☐	Are you pregnant?

Please describe any other disease, condition, problems or current medical treatment, including impending operations, recent injuries, or other information the doctor should be aware of: _____

_____

_____

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_____

(SEE OTHER SIDE)

DENTAL HISTORY

YES	NO	
☐	☐	Date of last dental examination _____
☐	☐	Are you allergic to any local anesthetics (Novocain, Xylocain)?

DO YOU HAVE OR HAVE YOU HAD, ANY OF THE FOLLOWING:

☐	☐	Previous orthodontic consultation or treatment?
☐	☐	Periodontal surgery or treatment?
☐	☐	Treatment for a temporomandibular joint disorder?
☐	☐	Clicking or soreness when the mouth is opened?
☐	☐	Oral surgery or x-ray treatment of the jaws, mouth or lips?
☐	☐	Teeth extracted or missing?
☐	☐	Problems with bleeding or gum healing after surgery?
☐	☐	Injuries to face, mouth, or teeth?
☐	☐	Grinding / clenching teeth?
☐	☐	Sensitivity to heat, cold or sweets?
☐	☐	Fluoride treatments?
☐	☐	Speech therapy?

Other: _____

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I certify that the above information is true and complete to the best of my knowledge.

_____

Signature

_____

Date