DANIEL A AVANT ORTHODONTICS DDS MSD PC

*"Orthodontics for Adults and Children"*

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Alamosa, CO 81101
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## PATIENT (CHILD)

Patient's Name _____ Appointment Date _____

Name Patient goes by _____ Referred by _____

Home Address _____ Zip Code _____

Home Phone _____ Birthdate _____ Age _____ Sex _____

Patient's Physician _____ Patient's Dentist _____

Patient's Hobbies and Interests _____ Email Address _____

Have any members of your family had orthodontics treatment at this office? Yes ☐ No ☐

If Yes, list names _____

**Father:**

**Name** _____

**Home Address** _____

_____ **Zip Code** _____

**Employer** _____

**Occupation** _____

**Business Phone** _____

**Mother:**

**Name** _____

**Home Address** _____

_____ **Zip Code** _____

**Employer** _____

**Occupation** _____

**Business Phone** _____

Person responsible for account _____ Phone _____

Address _____

Are you covered by dental insurance that provides for orthodontics treatment? Yes ☐ No ☐

Insured's Name _____ Date of Birth _____ Social Security / ID # _____

Employer _____ Occupation _____

Business Address _____

Insurance Carrier _____ Insurance Carrier's Address _____

Insurance Carrier's Phone _____ Policy #/ ID# _____

## DENTAL HISTORY

Date of Last Dental Visit: _____ Procedures Performed: _____

Your reason for seeking orthodontic treatment _____

Does patient have pain in face/mouth? Yes ☐ No ☐ If Yes, please describe _____

Has patient had blows or injuries to face/mouth? Yes ☐ No ☐ If Yes, please describe _____

Has patient been seen by another orthodontist? Yes ☐ No ☐ If Yes, describe treatment _____

Has patient had TMJ Treatment (jaw joints)? Yes ☐ No ☐

Is there difficulty breathing through nose (mouth breather)? Yes ☐ No ☐

Does patient have speech problems? Yes ☐ No ☐

Does patient have swallowing problems? Yes ☐ No ☐

## MEDICAL HISTORY

Is patient in good health? Yes ☐ No ☐

Is patient under physician's care? Yes ☐ No ☐ If Yes, for what reason? _____

_____

Is patient taking medications? Yes ☐ No ☐ If Yes, please list: _____

_____

Is patient allergic to medications? Yes ☐ No ☐ If Yes, please list: _____

_____

Has patient undergone X-ray treatment for tumors, growths or other conditions of the head or neck? Yes ☐ No ☐

If Yes, please describe: _____

Has patient been hospitalized, had a serious illness, or an accident within the last 5 years? Yes ☐ No ☐

If Yes, please describe: _____

Has patient had counseling, psychotherapy, or psychoanalysis? Yes ☐ No ☐

If Yes, please describe: _____

Does patient suffer from headaches or chronic ear infections? Yes ☐ No ☐

If Yes, please describe: _____

Has patient reached adolescent growth spurt? Yes ☐ No ☐

Has patient reached puberty (beginning of voice change, or start of menstruation)? Yes ☐ No ☐

If so, and within the last 2 years, when? _____

Does patient wear contact lenses? Yes ☐ No ☐

Has patient had tonsils or adenoids removed? Yes ☐ No ☐

Has patient had, or does patient currently have, any of the following?

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Diabetes | ☐ Hepatitis | ☐ Stomach Ulcers |
| ☐ Allergies | ☐ Epilepsy | ☐ Hormone Disorder | ☐ Tuberculosis |
| ☐ Arthritis | ☐ Fainting | ☐ Kidney Problems | ☐ Venereal Disease/AIDS |
| ☐ Asthma | ☐ Convulsions | ☐ Liver Problems | ☐ Other disorders/diseases: |
| ☐ Bone Disorder | ☐ Glaucoma | ☐ Prolonged Bleeding | |
| ☐ Cancer/Leukemia | ☐ Heart Problems | ☐ Rheumatic Fever | _____ |
| ☐ Osteoporosis | ☐ Osteopenia | ☐ Sinus Problems | |

Your reason for seeking orthodontic treatment _____

This dental and medical history has been completed to the best of my knowledge.

Signature of person completing form (Parent if patient is a minor)

_____ Date _____

## HISTORY UPDATE (Office Use Only)

History Update (Office Use Only)

_____ _____

_____ _____

_____ _____

_____ _____