



## WELCOME to the Orthodontist

My goal is to provide you with the best possible orthodontic experience. I consider it a privilege to work with you and I give you my word that I and my entire staff will do the very best for you that we can do. Please take a few moments to complete this form and bring it to your first visit.

Thank you,  
Charles E. Gulland, D.M.D.

### TELL US ABOUT YOU

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
Last - First - Middle

Nickname: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you lived at this address? \_\_\_\_\_

Home Phone: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies/Sports: \_\_\_\_\_  
\_\_\_\_\_

Are there any other children in the family?  Yes  No

Names and ages: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other family members seen by Dr. Gulland? \_\_\_\_\_  
\_\_\_\_\_

Whom may we thank for telling you about us? \_\_\_\_\_  
\_\_\_\_\_

General dentist: \_\_\_\_\_

Last visit date: \_\_\_\_\_  X-rays taken?

### ALTERNATE CONTACT INFORMATION

If we are unable to reach you list someone not living with you that we may contact.

His/Her name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Work #: \_\_\_\_\_ Home #: \_\_\_\_\_

### PARENT INFORMATION

#### Who is accompanying your child today?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you have legal custody?  Yes  No

Is your child adopted?  Yes  No

Does your child know?  Yes  No

Parent's marital status:

Single  Widowed  Married

Divorced  Separated

#### Mother's Information:

Stepmother  Guardian

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Employer: \_\_\_\_\_ SS #: \_\_\_\_\_

How long at current job? \_\_\_\_\_ Job title: \_\_\_\_\_

#### Father's Information:

Stepfather  Guardian

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Employer: \_\_\_\_\_ SS #: \_\_\_\_\_

How long at current job? \_\_\_\_\_ Job title \_\_\_\_\_

#### Who is responsible for making appointments?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Best tel. number to call for appt. during business hours?  
\_\_\_\_\_

#### Person responsible for account:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

How long at this address: \_\_\_\_\_

Previous address: \_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_

continued  
on back

## MEDICAL HISTORY

Does your child have a personal physician?  Yes  No

Physician's name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Your child's physical health is:  Good  Fair  Poor

Is your child currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Is your child taking any prescription/over the counter drugs?

Yes  No

Please list each one: \_\_\_\_\_

Is there anything you would like to discuss in private?

Yes  No

Are your child's immunizations current?  Yes  No

**For Girls:** Has menstruation begun?  Yes  No

If yes, when: \_\_\_\_\_

**For Boys:** Has puberty begun?  Yes  No

Has his voice changed?  Yes  No

Patient's present height? \_\_\_\_\_ Expected height? \_\_\_\_\_

Father's height? \_\_\_\_\_ Mother's height? \_\_\_\_\_

### Has your child ever had any of the following diseases or medical problems?

- |   |  |
|---|--|
| <input type="checkbox"/> Abnormal bleeding              | <input type="checkbox"/> Heart surgery/pacemaker     |
| <input type="checkbox"/> Anemia/Radiation treatment     | <input type="checkbox"/> Hemophilia                  |
| <input type="checkbox"/> Artificial bones/joints/valves | <input type="checkbox"/> Hepatitis                   |
| <input type="checkbox"/> Asthma/Arthritis               | <input type="checkbox"/> High/low blood pressure     |
| <input type="checkbox"/> Blood transfusion              | <input type="checkbox"/> HIV+/Aids                   |
| <input type="checkbox"/> Cancer/Chemotherapy            | <input type="checkbox"/> Hospitalized for any reason |
| <input type="checkbox"/> Congenital heart defect        | <input type="checkbox"/> Kidney problems             |
| <input type="checkbox"/> Diabetes/Tuberculosis          | <input type="checkbox"/> Mitral valve prolapse       |
| <input type="checkbox"/> Difficulty Breathing           | <input type="checkbox"/> Psychiatric problems        |
| <input type="checkbox"/> Drug/Alcohol abuse             | <input type="checkbox"/> Rheumatic fever             |
| <input type="checkbox"/> Emphysema/Glaucoma             | <input type="checkbox"/> Severe/Frequent headaches   |
| <input type="checkbox"/> Epilepsy/seizures/fainting     | <input type="checkbox"/> Shingles                    |
| <input type="checkbox"/> Fever blisters/herpes          | <input type="checkbox"/> Sinus Problems              |
| <input type="checkbox"/> Heart attack/stroke            | <input type="checkbox"/> Ulcers/colitis              |
| <input type="checkbox"/> Heart murmur                   | <input type="checkbox"/> Venereal disease            |

Please list any serious medical condition(s) that your child has ever had: \_\_\_\_\_

### Are they allergic to any of the following?

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Aspirin             | <input type="checkbox"/> Dental anesthetics | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Any metals/plastics | <input type="checkbox"/> Erythromycin       | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine             | <input type="checkbox"/> Latex              | <input type="checkbox"/> Other        |

Please list any other drugs/materials that they are allergic to:

\_\_\_\_\_  
\_\_\_\_\_

## Thank you for filling out this form completely

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services they may need.

Signature of Parent/Guardian

Date

## DENTAL HISTORY

Does your child like their smile?  Yes  No

What are the main concerns that you/they would like orthodontics to address? \_\_\_\_\_

Have they ever been evaluated for orthodontic treatment?

Yes  No

By whom? \_\_\_\_\_ When? \_\_\_\_\_

Their current dental health is:  Good  Fair  Poor

Have they ever had a serious/difficult problem associated with any previous dental work?  Yes  No

Do they require antibiotics before dental work?  Yes  No

How many times daily do they brush? \_\_\_\_\_

Do they floss their teeth daily?  Yes  No

Do their gums bleed?  Yes  No

Is their water fluoridated?  Yes  No

Are they taking fluoridated supplements?  Yes  No

### Do they have or have they ever had any of the following habits?

- |  |  |
|--|--|
| <input type="checkbox"/> Nursing bottle habits | <input type="checkbox"/> Lip sucking/biting    |
| <input type="checkbox"/> Speech problems       | <input type="checkbox"/> Mouth breather        |
| <input type="checkbox"/> Thumb/finger sucking  | <input type="checkbox"/> Nail biting           |
| <input type="checkbox"/> Tongue thrust         | <input type="checkbox"/> Were they breast fed? |
| <input type="checkbox"/> Clench/grind teeth    |  |

Do they generally breath through their mouth?  Yes  No

If yes:  While awake  While asleep

Have their adenoids or tonsils been removed?  Yes  No

Do they have any speech problems? \_\_\_\_\_

Do they still have any wisdom teeth?  Unsure  Yes  No

Have they ever had an injury to their?  Mouth  Teeth  Chin

### Do they now or have they ever experienced pain/discomfort in their jaw joint (TMJ/TMD)? Yes No

## ADDITIONAL INFORMATION

Any additional information you can give us would be appreciated as the more we know about each other, the better we can help manage your treatment both at home and in the office.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian named herein. Staff initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian

Date