



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: _____

Other Family Members seen by Dr. Gulland? _____

Are there any other children in the family? Yes No

Names and ages: _____

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 you today?

Name: _____ Relationship: _____

Does this person have legal custody of you? Yes No

Are you adopted? 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: _____

MEDICAL HISTORY

Does your child have a personal physician? Yes No

Physician's name: _____

Phone #: _____ Date of last visit: _____

Their physical health is: Good Fair Poor

Are they currently under the care of a physician? Yes No

Please explain: _____

Are they 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

Do they smoke or use tobacco of any form? Yes No

Are their immunizations current? Yes No

For Girls: Has menstruation begun? Yes No

If yes, when: _____

Are they taking birth control pills? Yes No

Are they pregnant? Yes No

Week #: _____

Are they nursing? Yes No

For Boys: Has puberty begun? Yes No

Has their voice changed? Yes No

Patient's present height? _____ Expected height? _____

Father's height? _____ Mother's height? _____

Have they 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 they have 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: _____

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: _____

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.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date