



# Heather A. Lindsay

D D S • M S  
ORTHODONTICS

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*We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and enjoyable.*

## 1. Tell Us About Your Child

Today's Date

Child's Name

Name Preferred  Male  Female

Child's Birth date Child's Age

School Grade

Child's Home #

Child's Home Address

City, State, Zip

## 2. Who is Accompanying the Child Today

Name Relation

Do you have legal custody of this child? Yes  No

Other family members seen by us

Relationship

## 3. Mother's Information

Birth Mother  Step Mother  Adoptive  Guardian

Name

Work Ph. Home Ph.

Employer How Long

Occupation SS#

Email address

Married  Divorced  Separated  Single  Widowed

## 4. Father's Information

Birth Father  Step Father  Adoptive  Guardian

Name

Work Ph. Home Ph.

Employer How Long

Occupation SS#

Email address

Married  Divorced  Separated  Single  Widowed

## 5. Person Responsible for Account

Name Relation

Billing Address

City, State, Zip

Work Ph. Home Ph.

Employer DL No.

SS# Date of Birth

## 6. Primary Dental Insurance

Insurance Co. Name

Insurance Co. Phone No.

Insured's Name

Relationship to Patient

Insured's Birth date SS#

Insured's Employer

### 7. Has the child ever had any of the following medical problems?

- |   |   |
|---|---|
| <u>Yes/No</u>   | <u>Yes/No</u>   |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur    | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis (TB)       |
| <input type="checkbox"/> <input type="checkbox"/> Cancer          | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes        | <input type="checkbox"/> <input type="checkbox"/> Convulsions/Epilepsy    |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Hearing Impairment      |
| <input type="checkbox"/> <input type="checkbox"/> HIV+/AIDS       | <input type="checkbox"/> <input type="checkbox"/> Endocrine Problems      |
| <input type="checkbox"/> <input type="checkbox"/> Hemophilia      | <input type="checkbox"/> <input type="checkbox"/> Kidney/Liver Problems   |
| <input type="checkbox"/> <input type="checkbox"/> Asthma          | <input type="checkbox"/> <input type="checkbox"/> Handicaps/Disabilities  |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis       |   |

Please discuss any serious medical problems that the child has had:

\_\_\_\_\_

\_\_\_\_\_

Child's current physical health:  Good  Fair  Poor

Medications the child is currently taking:

Medications the child is allergic to

### 8. Dental History

Why did you bring the child to the orthodontist today?

Present/Previous Dentist

Date of Last Visit

Has the child ever had any of the following:

- Yes/No
- Serious/difficult problem associated with previous dental work?
- Tonsils or adenoids removed?
- Pain/tenderness in their jaw joint
- Thumb or finger sucking

Who may we thank for referring you to our office?

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

#### Office Use Only

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	Jaw	RIGHT SIDE		LEFT SIDE	
		Molar	Cuspid	Molar	Cuspid
Class I					
Class II					
Div.I					
Div.II					
Class III					

Oral Hygiene  Excellent  Good  Fair  Poor

TMJ  Normal  Popping/Crepitus L/R  Pain/L/R

Lip/Muscle Posture  Lip Strain  Mentalis Strain

Arch length:

Upper  Excess  Adequate  Deficient \_\_\_\_\_mm

Lower  Excess  Adequate  Deficient \_\_\_\_\_mm

Overbite  Deep  Normal  Open \_\_\_\_\_%

Overjet \_\_\_\_\_mm

Habits  Tongue thrust  Thumb/finger

Mouthbreathing

Abnormal frenum  Upper  Lower

Probable  Extraction  Non-Extraction  Borderline

Crossbite: R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L  
R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L

Midline R \_\_\_\_\_ L

Deciduous Teeth R \_\_\_\_\_ E D C B A A B C D E \_\_\_\_\_ L  
E D C B A A B C D E

Missing

Permanent Teeth R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L  
R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Recommendation:  Treat Now \_\_\_\_\_  
 Recall:  3 mo.  6 mo.  1 yr.  
 No treatment

Estimated Tx Time \_\_\_\_\_ Months \_\_\_\_\_ Fee

U/L Clarity \_\_\_\_\_

U/L Invisalign \_\_\_\_\_

Next Appt: \_\_\_\_\_

Letters:

Records TBD  Wait for TX  NC  TY Re  FU Pt