



Dr. Renee Doyle
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CHILD ORTHODONTIC PATIENT QUESTIONNAIRE

Patient's name: Preferred name:
Date of Birth: Sex: M F E-mail address:
Address: Street:
City: State: Zip: Telephone: ()
Name of School: Grade level:
Hobbies/Interests:

Name of responsible party: Preferred name:
Address: Street: City:
E-mail address:
Home Phone:() Work Phone:() Cell Phone: ()
Why are you and your child seeking orthodontic treatment? (Please be as specific as possible):

Who may we thank for referring you to our office?

I am interested in the following (check all that apply) Metal Braces Ceramic Braces Invisalign Other

FAMILY STATUS

Father's name: Cell phone: ()
Occupation: Employer: Work Phone: ()
Mother's name: Cell phone: ()
Occupation: Employer: Work Phone: ()
Marital Status of parents: Is the patient adopted? Yes No
Brother & Sisters:

INSURANCE INFORMATION Will you be using dental insurance? Yes No

Insurance company: Group Number:
Telephone Number: ()
Name of Subscriber: Employer:
Subscriber's Date of Birth SS#

DENTAL HISTORY

General Dentist: Phone:()
Date of last dental examination:
Has another member of the family had orthodontic treatment? Yes No Who?
Has this patient had a previous orthodontic consultation? Yes No Where?
Has the patient ever had trauma/damage to the teeth, jaws, or gums? Yes No

MEDICAL HISTORY

Family Physician: _____ Phone: (____) _____

Are you currently under a physician's care? Yes No
If yes, please explain _____

Are you taking any medicine at this time? Yes No
If yes, please list _____

Are you allergic to any medications? Yes No
If yes, please list _____

Do you have any other allergies? Yes No
If yes, please list _____

Do you need to be premedicated (with antibiotics) for routine dental procedures? Yes No
If yes, please specify and give reason for this need: _____

Have you ever been hospitalized? Yes No
If yes, please explain _____

Females: Are you pregnant? Yes No

Does the patient have or has the patient ever had any of the following?

- | | | | | | |
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| Yes | No | Yes | No | Yes | No |
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Does the patient have any disease, condition, or problem not listed above?
Please explain: _____

DOES/DID THE PATIENT:

Grind his/her teeth at night? Yes No Brush his/her teeth Often Occasionally Reluctantly
Suck thumb, finger, pacifier? Yes No If yes, what age was the habit discontinued? _____

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT

Is the patient aware of the problem? Yes No
The patient's interest in having treatment is: Excited Willing if necessary Reluctant

BEHAVIOR ASSESSMENT

Personality (check any that apply):
 Calm Nervous Quiet Shy Outgoing Uncooperative Cooperative
 Confident Afraid Emotional disturbance
Progress at school when compared to children of the same age: Behind Same Level Advanced

GROWTH STATUS:

Height: _____ Weight: _____
Females: Has the patient started her menstruation? Yes No If yes, what age? _____
Males: Has the patient yet undergone voice changes? Yes No Facial hair growth? Yes No

Thanks for your help. We're excited to get to know you better!

Signature of the person completing this form: _____

Relationship to the patient: _____ Today's Date: _____