Hamden & Guilford Locations

(203) 288 – 0900

www.dobierevolution.com

PATIENT INFORMATION *for* CHILD

Date:_____________________

Childs's Name:_____________________ Nickname:_____________ Gender:_______

Date of Birth:_____________________ Age:_____ School:_____________________ Grade:_______

Child's Hobbies: _____________________

Has anyone in your family been treated in our office?_____________________

Please list all sibling(s) & age(s):_____________________

Please CIRCLE how you would you like to receive appointment reminders: Email Text Message Both

Parent / Guardian	Parent / Guardian
Name: _____________	Name: _____________
Marital Status: _____________	Marital Status: _____________
Address: _____________	Address: _____________
_____________	_____________
Cell #: _____________	Cell #: _____________
Home #: _____________	Home #: _____________
Email: _____________	Email: _____________
Date of Birth: _____________	Date of Birth: _____________
Social Security #: _____________	Social Security #: _____________
Occupation/Employer: _____________	Occupation/Employer: _____________

Responsible Party Name: _____________________

How did you find us? Dentist Invisalign Website Google Search Social Media Friend:_____________

Are you on Facebook? Yes No Please follow us: www.facebook.com/dobierevolution

Are you on Instagram? Yes No Please follow us: @dobierevolution

GROWTH ASSESSMENT

Has the patient grown in the last year? Yes No How much:__________

Child's height:__________ Mother's height:__________ Father's height:__________

Has the patient's shoe sized changed recently? Yes No How much:__________

Has the patient reached puberty? Yes No

TURN OVER

MEDICAL HISTORY

Please Circle All Conditions That Apply:

Heart abnormality	Diabetes	Cancer/Tumor	Hearing Impairment
Rheumatic/Scarlet fever	HIV/AIDS	GI Disorder	Speech Disorder
Artificial Heart Valve	Hepatitis	Epilepsy/Seizures	Fainting/Dizziness
High/Low Blood Pressure	Bronchitis	Autism	Nervous/Anxious
Kidney/Liver problems	Asthma	Cleft Lip/Palate	Tactile Defensive
Bleeding Abnormality	Thyroid Disorder	Birth Defect(s)	Major Surgery
Sickle Cell Anemia	Bone Disorder	Growth Disorder	Currently Pregnant
Tuberculosis	Artificial Joints	Tonsils/Adenoids removed	**NONE**

If circled, please explain: ______________________________

Condition not listed: ______________________________

Any allergies? Yes No Please explain: ______________________________

Any medications? Yes No Please explain: ______________________________

DENTAL HISTORY

Dentist's Name:	Last Dental Visit:
Any previous orthodontic consults? Yes No	If so when:
Any previous orthodontic treatment? Yes No	Please explain:
Main orthodontic concern:	

Prior facial/dental injuries: ______________________________

Oral habits (e.g. sucking thumb): ______________________________ Until age: __________

TMJ problems (clicking or pain): ______________________________

Excessive grinding/clenching: ____________________ Mouth breathing: ____________________

Tongue Thrusting: ________________ Missing or extra permanent teeth: ____________________

Any family history of jaw/orthognathic surgery: ______________________________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the practice of any medical or dental changes to this record.

Parent / Guardian Signature: ______________________________ **Date:** ______________

OFFICE USE ONLY

Right: Class I Class II______ Class III______ X-B______

Left: Class I Class II______ Class III______ X-B______

OJ: __________ **OB**: ________ Deep ________ Open _______

Upper: Crowding _____________ Spacing _____________

Lower: Crowding _____________ Spacing _____________

Other: ______________________________

____

OH: _______ **Recall:** __________ **Ins:** _____________

Tx Plan: ______________________________

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Est. Fee: _____________ **Est. Time:** _____________