

ForeOrthodontics

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Certified, American Board of Orthodontics
706. 291.0383

Date: _____

**Please answer all questions accurately. We consider all answers to be confidential.
(This is a permanent record. Please use ink.)**

School: _____ Grade: _____

Patient's Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Male _____ Female _____

Hobbies: _____ Sports: _____

Name of Parents: Father: _____ Mother: _____
Parents Marital Status _____

Brothers & Sisters: _____ Age _____
_____ Age _____
_____ Age _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home (____) _____ Cellular (____) _____ Pager (____) _____

Patient Email: _____ Parent Email: _____

Employed by: Father: _____ Telephone (____) _____
Mother: _____ Telephone (____) _____

Present position: Father: _____ How Long: _____
Mother: _____ How Long: _____

How did you hear about Dr. Fore? (Circle all that apply) Dentist School Friend Family Mailer Card

Who referred you to our office? _____

Persons responsible for this account: _____

Name of dental insurance company and policy #: _____

Social Security Number*: Father: _____ Mother: _____

****Routine credit checks are required for office financing (good credit standing is required). Your initials authorize this check.****

MEDICAL HISTORY

Name of dentist: _____ Date of last visit: _____

Date of last medical examination: _____

Physician: _____ Phone # (____) _____

Is your child presently under a physician's care? _____

Does your child have any serious recurrent illnesses? _____

Has your child had any medical x-rays in the last year? _____

Does your child have any allergies or an allergic reaction to any medications? Yes _____ No _____

If yes, please explain: _____

Is your child currently taking any medications? _____

If yes, please explain: _____

DOES YOUR CHILD HAVE, OR HAS HE OR SHE EVER HAD, ANY OF THE FOLLOWING: **Child page 2**

	YES	NO		YES	NO
1. Diabetes	_____	_____	11. Heart murmur	_____	_____
2. Hepatitis.....	_____	_____	12. Mitral valve prolapse	_____	_____
3. HIV positive	_____	_____	13. Anemia	_____	_____
4. AIDS	_____	_____	14. Liver disease	_____	_____
5. Asthma	_____	_____	15. Endocrine (gland) disease	_____	_____
6. Rheumatic fever	_____	_____	16. Kidney disease	_____	_____
7. Heart disease	_____	_____	17. Phenylketonuria	_____	_____
8. Rheumatoid/arthritis conditions	_____	_____	18. Convulsions	_____	_____
9. High blood pressure	_____	_____	19. Fainting spells or seizures	_____	_____
10. Abnormal bleeding from a cut	_____	_____	20. Tuberculosis	_____	_____

If you answered "yes" to any of the above questions, please explain: _____

Does your child have an allergy to latex? (i.e. gloves) Yes _____ No _____

Does your child need preventive antibiotic coverage for dental procedures? (i.e., dental cleanings) Yes _____ No _____

Are there any other physical, emotional, or mental conditions? _____

Does your child use any type of tobacco product? Yes _____ No _____

DENTAL HISTORY

Is your child a mouth breather?.....Does your child snore? (circle if apply)	YES	NO	
	_____	_____	

Has your child had any injuries to the teeth (chips, falls, or blows)?	_____	_____	
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Did your child, or does he or she presently, have any habits such as nail biting, chewing on pencils, thumbsucking, etc.? (Circle all that apply)	_____	_____	
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Does your child grind or clench his or her teeth?	_____	_____	
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Have you previously consulted an orthodontist? Yes _____ No _____		How long ago? _____
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Has your child had any orthodontic treatment?	_____	_____	
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When were his or her last dental x-rays taken? _____

How often does he or she brush? _____ Floss? _____

Does your child play a wind instrument?	_____	_____	
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Does your child take speech therapy? Yes _____ No _____		Has your child ever had speech therapy? Yes _____ No _____
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If yes, what letters did he or she need to improve? _____

Please indicate if your child has experienced, or presently experiences, any of the following:	Headaches _____		
Earaches _____	Neckaches _____	Ringing in the ears _____	Jaw pain _____

If you answered "yes" to any of the above, please indicate if treatment was given and by whom: _____

Are there any sensitive teeth? _____	Have any teeth been removed? _____
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Please list the dentists and dental specialists that have treated your child in the last five years: _____

What are your reasons for seeking orthodontic treatment for your child? _____

I, the undersigned, have given the above medical and dental information. If there are any changes during my orthodontic treatment, I will inform this practice.

Parent (Legal Guardian) Signature: _____ **Date:** _____