SALMON ORTHODONTICS

Professional Corporation

Dr. Marlin Salmon and Dr. Deborah deSa

Practice Limited to Orthodontics for Children and Adults

IN ORDER TO PERFORM A MORE COMPLETE SERVICE FOR OUR PATIENTS, WE ASK YOUR COOPERATION IN COMPLETING THIS QUESTIONNAIRE.

PATIENT INFORMATION

Patient Name _____ M □ F □

Soc. Sec. # _____ Nickname _____ Birthdate _____

Address _____ Tel. # _____

Street City/State Zip

E-Mail Address _____ Cell # _____

Do you wish to have E-mail appointment reminders? Yes □ No □

Do you wish to have Text Message appointment reminders? Yes □ No □

Dentist _____ Address _____

Street City/State Zip

Physician _____ Address _____

Street City/State Zip

Referred by _____

School _____ Grade _____ Sports _____

Play a musical instrument? _____ Hobbies _____ Interests _____

RESPONSIBLE PARTY INFORMATION

Father's Name _____ Birthdate _____ Soc. Sec. # _____

Address _____

How long at this address? _____ If less than 3 years, previous address _____ How long? _____

E-Mail Address _____ Cell # _____

Do you wish to have E-mail appointment reminders? Yes □ No □

Do you wish to have Text Message appointment reminders? Yes □ No □

Occupation _____ Business Tel. No. _____

Business Name _____

Mother's Name _____ Birthdate _____ Soc. Sec. # _____

Address _____

How long at this address? _____ If less than 3 years, previous address _____ How long? _____

E-Mail Address _____ Cell # _____

Do you wish to have E-mail appointment reminders? Yes □ No □

Do you wish to have Text Message appointment reminders? Yes □ No □

Occupation _____ Business Tel. No. _____

Business Name _____

Person(s) Financially Responsible _____ Relationship _____

Insurance covering orthodontics _____ Carrier _____

ORTHODONTIC INFORMATION

1. Reason for orthodontic consultation: _____

2. Previous treatment - patient or others in immediate family:

   Yes ☐ No ☐ If yes, who? _____

   With what results? _____Excellent _____ Good _____Poor

3. Have you had a previous orthodontic consultation?

   Yes ☐ No ☐ If yes, with whom? _____

4. What do you consider to be the main benefits of orthodontic correction?

   _____Cosmetic _____ Functional _____Psychological/Emotional Other _____

   Which are factors in this instance? _____

5. Is patient self-conscious of his/her teeth?

   Yes ☐ No ☐ If yes, please explain _____

6. Patient's attitude toward orthodontic treatment: _____ Enthusiastic _____Indifferent _____Resentful

7. Expected patient cooperation: _____Excellent _____ Good _____Fair _____Poor

8. Are both parents in favor of treatment?

   Yes ☐ No ☐ _____

9. Are parents aware that orthodontic appointments will infringe on school time?

   Yes ☐ No ☐ _____

MEDICAL HISTORY

1. Patient size: _____Average _____Large _____Small

   Height _____ Weight _____ Father's Ht. _____ Mother's Ht. _____ Adopted _____ Natural Child _____

2. Present state of health: _____Excellent _____ Good _____Fair _____Poor

3. Currently under physician's care:

   Yes ☐ No ☐ Why? _____

   _____

4. Currently taking medications including dietary supplements:

   Yes ☐ No ☐ What? _____

   _____

5. Is there any **patient** history: (If you answer **yes** to any of the following questions, please explain to the right of the question.)

   Yes ☐ No ☐ Facial accidents? _____
   Yes ☐ No ☐ Facial operations? _____
   Yes ☐ No ☐ Environmental allergies? Food allergies? _____
   Yes ☐ No ☐ Allergies to medication? _____
   Yes ☐ No ☐ Emotional disorders? _____
   Yes ☐ No ☐ Vision impairment? _____
   Yes ☐ No ☐ Hearing problems? _____
   Yes ☐ No ☐ Tonsillitis? _____
   Yes ☐ No ☐ Speech problems? _____
   Yes ☐ No ☐ Blood disorders? _____
   Yes ☐ No ☐ Immune System Disorders? _____
   Yes ☐ No ☐ Birth defects? _____
   Yes ☐ No ☐ Asthma? _____
   Yes ☐ No ☐ Anemia? _____
   Yes ☐ No ☐ Diabetes? _____
   Yes ☐ No ☐ Hepatitis? _____
   Yes ☐ No ☐ Rheumatic Fever? _____

Yes □ No □ Epilepsy? _____
Yes □ No □ Heart Disease problems including murmurs? _____
Yes □ No □ Liver or Kidney disease? _____
Yes □ No □ TMJ (jaw joint problems)? _____
Yes □ No □ Arthritis? _____
Yes □ No □ Osteoporosis? Bisphosphonate medications? _____

6. Serious illness other than usual childhood disorders? _____

_____

7. Has the patient ever been hospitalized?

Yes □ No □ If yes, for what and the date: _____

_____

8. Is the patient under psychological guidance?

Yes □ No □ If yes, for what? _____

Mental development: _____ Above Average _____ Average _____ Below Average

DENTAL HISTORY

1. When was patient's last visit to his/her general dentist? _____
2. Has patient had: _____ Previous dental treatment? _____Regular dental check-ups? _____X-rays?
   _____Extractions? _____Impressions?
3. Has patient ever lost or chipped any teeth?

   Yes □ No □ If yes, explain the circumstances _____
4. Eruption of teeth: _____Early _____Average _____Late _____Markedly delayed
5. Oral hygiene habits: _____Good _____Poor Intake of sweets: _____High _____Moderate _____Low
6. Has the patient ever received a blow to the teeth or jaws?

   Yes □ No □ If yes, please explain: _____

   _____
7. Indicate habits, past or present, relating to the mouth or face:

   Yes □ No □ Thumb □ Finger □ Object □ sucking? _____
   Yes □ No □ Mouth breathing? _____
   Yes □ No □ Lip biting? _____
   Yes □ No □ Tongue thrust (reverse swallow)? _____
   Yes □ No □ Chewing habits? _____
   Yes □ No □ Nail biting? _____
   Yes □ No □ Postural habits? _____
   Yes □ No □ Sleeping habits (blanket sucking)? _____
   Yes □ No □ Tooth grinding/clenching? _____
   Yes □ No □ Poor speech habits? _____
8. Is there any hereditary background (familial tendency) which might contribute to this orthodontic problem?

   _____

   _____

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 this office, use the services of one or more credit reporting service.

Signed _____ Date _____
(Parent or Guardian)