

**KOK-TOW NG, D.D.S.**

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*Specialist in Orthodontics and Dentofacial Orthopedics*

**CONFIDENTIAL PATIENT INFORMATION**

Patient's name \_\_\_\_\_ He/she prefers to be called \_\_\_\_\_ Sex:  Female  Male

Birthdate \_\_\_\_\_ Age: \_\_\_\_\_yr. \_\_\_\_\_mths. School \_\_\_\_\_ Grade \_\_\_\_\_

Home Address \_\_\_\_\_ City & Zip \_\_\_\_\_ Phone (H) \_\_\_\_\_

Father \_\_\_\_\_ Occupation \_\_\_\_\_ SS# \_\_\_\_\_

Mother \_\_\_\_\_ Occupation \_\_\_\_\_ SS# \_\_\_\_\_

Name and address of person responsible for account \_\_\_\_\_ Phone (W) \_\_\_\_\_

Patient lives with  Both parents  Father  Mother  Other \_\_\_\_\_ Do you anticipate a move in the near future?  Yes  No

Name of Orthodontic Ins.Coy. \_\_\_\_\_ Policy number \_\_\_\_\_ Birthdate of insured \_\_\_\_\_

Child's physician \_\_\_\_\_ Phone \_\_\_\_\_ Child's dentist \_\_\_\_\_ Phone \_\_\_\_\_

Is patient adopted?  Yes  No Face & mouth of patient most resemble  Father  Mother Did parent(s) wear braces?  Yes  No

Height of patient \_\_\_\_\_ How much has your child grown in the past year? \_\_\_\_\_ Have your child reached puberty?  Yes  No

Describe your child's temperament \_\_\_\_\_ What are his/her hobbies/sports? \_\_\_\_\_

Name & Birthdates of brothers and sisters \_\_\_\_\_

When and how is the best time to reach you? \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_

**MEDICAL HISTORY**

For the following questions mark yes or no. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

**Now or in the past, have your child had:**

- yes  no Birth defects or hereditary problems?  yes  no Bone fractures, any major accidents?
- yes  no Rheumatoid or arthritic conditions?  yes  no Endocrine or thyroid conditions?
- yes  no Diabetes?  yes  no Cancer, tumor, radiation treatment or chemotherapy?
- yes  no Polio, mononucleosis, tuberculosis, pneumonia?  yes  no Problems of the immune system?
- yes  no AIDS or HIV positive?  yes  no Hepatitis, jaundice or liver problems?
- yes  no Fainting spells, seizures, or neurological problems?  yes  no High or low blood pressure?
- yes  no Excessive bleeding or bruising tendency, anemia or bleeding disorder?  yes  no Cardiovascular problem (heart murmur, rheumatic heart disease or heart attack)
- yes  no History of eating disorder (anorexia, bulimia)?  yes  no Frequent headaches, colds or sore throats?
- yes  no Hay fever, asthma, sinus trouble or hives?  yes  no Mental health disturbance or depression?
- yes  no Tonsil or adenoid conditions?  yes  no Eye, ear, nose or throat condition?

**Now or in the past, have your child had allergies or reactions to any of the following?**

- yes  no Aspirin  yes  no Ibuprofen (Motrin, Advil)  yes  no Penicillin or other antibiotics
- yes  no Sulfa drugs  yes  no Codeine or other narcotics  yes  no Metals (jewelry, clothing snaps)
- yes  no Latex (gloves, balloons)  yes  no Vinyl  yes  no Acrylic
- yes  no Foods (specify) \_\_\_\_\_  yes  no Other substances (specify) \_\_\_\_\_

**PATIENT PROFILE**

- yes  no Does your child follow directions well?                       yes  no Does your child brush his/her teeth conscientiously?
- yes  no Does your child have learning disabilities or need extra help with instructions?
- yes  no Is your child sensitive or self-conscious about teeth?

**DENTAL HISTORY**

**Now or in the past, have your child had:**

- yes  no Started teething very early or late?     yes  no Primary (baby) teeth removed that were not loose?
- yes  no Permanent or 'extra' (supernumerary) teeth removed?                       yes  no Supernumerary or congenitally missing teeth?
- yes  no Chipped or otherwise injured any teeth?     yes  no Teeth sensitive to hot or cold, or ache?
- yes  no Jaw fractures, cysts or mouth infections?     yes  no 'Dead teeth' or root canals treated?
- yes  no Bleeding gums, bad taste or mouth odor?     yes  no Periodontal 'gum problems'?
- yes  no Food impaction between teeth?     yes  no 'Gum boils', frequent canker sores or cold sores?
- yes  no Thumb, finger or sucking habit? Until what age \_\_\_\_\_?                       yes  no Abnormal swallowing habit (tongue thrusting)?
- yes  no History of speech problems?     yes  no Mouth breathing habit, or snoring?
- yes  no Tooth grinding or jaw clenching?     yes  no Any soreness in the muscles of the face or jaws?
- yes  no Difficulty in chewing or jaw opening?     yes  no Have you ever been treated for 'TMJ' problems?
- yes  no Aware of loose, broken or missing fillings?     yes  no Any teeth irritating cheek, lip, tongue or palate?
- yes  no Concerned about spaced, crooked or protruding teeth?                       yes  no Concerned about under or over developed jaw?
- yes  no Any relative with similar tooth or jaw relationships?                       yes  no Any wisdom tooth problems?
- yes  no Had periodontal (gum) treatment?
- yes  no Had any serious trouble associated with any previous dental treatment?
- yes  no Ever had a prior orthodontic examination or treatment?
- yes  no Would your child object to wearing orthodontic appliances (braces) should they be indicated?

**CURRENT MEDICAL AND DENTAL HEALTH**

Is your child currently under the care of a physician?  Yes  No If yes, please state reason(s) \_\_\_\_\_

Did your child have any serious medical problems in the last 5 years?  Yes  No If yes, please explain \_\_\_\_\_

Is your child currently taking any drugs prescribed by a physician or dentist?  Yes  No If yes, please list \_\_\_\_\_

The approximate date of your child's last dental visit \_\_\_\_\_ Reason \_\_\_\_\_

How often does your child brush: \_\_\_\_\_ Floss \_\_\_\_\_ Does your child like his/her smile?  Yes  No

What are your reasons for bringing your child in for a consultation today? \_\_\_\_\_

*I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.*

Signed: \_\_\_\_\_ Date signed: \_\_\_\_\_  
(Parent/Guardian)

Signed: \_\_\_\_\_ Date signed: \_\_\_\_\_  
(Dental staff member)

PLEASE FILL OUT THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT