Stephen W. Bradford, D.M.D., P.A.
Practice Limited to Orthodontics and Dentofacial Orthopedics
***Member* AMERICAN ASSOCIATION OF ORTHODONTISTS**

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Patient History and Acquaintance Information (Child)

Please Complete All Blanks

Date:_____ Family Dentist**:**_____ Referred by: _____
Name:_____ Nick name:_____
Age: _____ Birth date: __/__/____ Patients Sex: **M/F**
School:_____ Grade:_____ **E-mail**:_____
What type of student is the patient? ____Excellent ____Good ____Average
Hobbies:_____
Name and ages of other children in the family:_____
Patient's height: _____ Patient's weight: _____ Increase in past year: Height____ Weight ___
Father's height: _____ Mother's height: _____ Patient resembles: Mother___ Father___ Neither___
Growth and Development | Girls: Has menstruation begun? _____Yes _____No When? _____
Boys: Has voice changed? _____Yes _____No When? _____

Dental and Medical History

Has an Orthodontist been consulted previously? ____Yes _____No Dr:_____ Date:_____
Does the patient want teeth straightened? _____Yes _____No
Is the patient aware of any orthodontic problem? _____Yes _____No
Date of last dental checkup:_____ Were the teeth cleaned? _____Yes _____No
How many times per day does the patient **brush** their teeth? ____0 _____1_____2_____3 **floss?**___0___1___2

Check Yes or No for which the patient has been diagnosed or treated. If Yes, please specify.

__Yes __No Anemia	__Yes __No Herpes	__Yes __No Speech Problems
__Yes __No Blood Disease	__Yes __No Tonsillitis/Adenitis	__Yes __No Head/Face Injuries
__Yes __No Hepatitis	__Yes __No Tonsils Removed	__Yes __No Dental Injuries
__Yes __No Risk Group/AIDS	__Yes __No Adenoids Removed	__Yes __N Thumb/Finger Habit
__Yes __No Jaundice	__Yes __No Asthma	__Yes __No Difficult Oral Surgery
__Yes __No Rheumatic Fever	__Yes __No Mouthbreathing	__Yes __No Clench/Grind Teeth
__Yes __No Heart Disease	__Yes __No Allergies	__Yes __No Missing/Extra Teeth
__Yes __No Tuberculosis	__Yes __No Drug Sensitivity	__Yes __No Clicks/Pops of Jaw Joint
__Yes __No Diabetes	__Yes __No Under Physicians Care	__Yes __No Frequent Head/Ear Aches
__Yes __No Endocrine Problems	__Yes __No Systemic Medications	__Yes __No Need to Premedicate
__Yes __No Bone Disorders	__Yes __No Unusual Illnesses	__Yes __No Any Current Medications
__Yes __No Epilepsy/Seizures	__Yes __No In Good Health	__Yes __No Any Other Concerns

Specific Notes: _____
_____
Any Known Allergies: _____
Patients Family Physician:_____ Phone:_____ Date of last visit:_____
Would you consider patient's health to be: _____Excellent _____Good _____Fair _____Poor?
Person(s) to be Notified in Case of Emergency: _____Phone:_____

I hereby certify that I have reviewed the above health history and that it is accurate to my knowledge at this time. If there are any future changes in this information, I will inform Dr. Bradford and staff of these changes. This information, important for our records and your health is confidential.

Signature of Responsible Party: _____Date:_____
Updates: _____/_____/_____/_____

Patient Information

Patient's name_____
Address: _____
Home Phone: _____ Cellular Phone/Beeper: _____
Birthdate: __/__/____ Sex: _____
Social Security #: _____ E mail address: _____
If patient is a minor, give parent's or guardian's name: _____
Whom may we thank for referring you to our office?: _____
General Dentist: _____
Family member in or out of orthodontic treatment:_____

Responsible Party Information

Name: _____
Mailing Address: _____
How long at this address: _____ Home Phone: _____
Previous Address (if less than 3 years)_____ How long:_____

Father's Name: _____Marital Status:_____ (If spouse is other than mother, fill out spouse line)

Soc. Sec. #:_____ Dr. License #:_____DOB: _____

Employer:_____ Occupation: _____ # of years employed: ____ Work Phone: _____

Employer Address: _____

Spouse:_____ Soc. Sec. #:_____ Dr. License #:_____DOB: _____

Mother's Name: _____Marital Status:_____ (If spouse is other than father, fill out spouse line)

Employer: _____ Occupation: _____ # of years employed: _____ Work Phone:_____

Soc. Sec. #:_____ Dr. License #:_____DOB: _____

Employer Address: _____

Spouse:_____ Soc. Sec. #:_____ Dr. License #:_____DOB: _____

Insurance Information

Insured's Name: _____Insured's Social Security #: _____
Insurance Company: _____ Group#: _____ Local #: _____
Insurance Company Address: _____ Phone#: _____
Do you have dual coverage? _____Yes _____No If yes, please complete the information below.
Insured's Name: _____Insured's Social Security #: _____
Insurance Company: _____ Group#: _____ Local #: _____
Insurance Company Address: _____ Phone#: _____

I, _____, give Dr. Bradford's office permission to check my credit history through the Credit Bureau. I understand that by doing so there will be a notation on my record of the inquiry. This inquiry is necessary to obtain financing through Dr. Bradford's office for orthodontic care of the above named patient. _____

Signature (Parents if minor): _____ **Date:**_____

Previous Orthodontist Information

If transferred, name of previous orthodontist: _____ Phone:_____
Complete Address: _____