

Dr. Richard A. Fernandes D.D.S. M. DPH, Cert. Ortho. FRCD(C)  
Specialist in Orthodontics for Children and Adults

## Orthodontic Patient Information Sheet (Child)

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: \_\_\_\_\_  
MM DD YYYY

Patient's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov. \_\_\_\_\_ P.C. \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Father: \_\_\_\_\_ Work Number: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Mother: \_\_\_\_\_ Work Number: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_

Responsible Party's Name: \_\_\_\_\_

Siblings' Name: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

Do you have insurance? YES/NO      Company: \_\_\_\_\_ Policy # \_\_\_\_\_  
Certificate #: \_\_\_\_\_

Is this appointment prompted by: **JAW JOINT PROBLEMS** or **ORTHODONTICS**? (CIRCLE)

Have you consulted an orthodontist before?      Yes or No

Whom may we thank for referring you to us? \_\_\_\_\_

What are your main reasons for consulting Dr. Fernandes? \_\_\_\_\_

Are there any other family members with similar problems?      Yes or No

Patient's Dentist: \_\_\_\_\_ Patient's Physician: \_\_\_\_\_

Dentist # \_\_\_\_\_ Physician's #: \_\_\_\_\_

Is there an Emergency contact person?

Yes – Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## Patient Medical History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Are your jaw joints uncomfortable? Yes / No

Do they ever make clicking/popping/crunching noises? Yes / No

Do they ever get locked/stuck/hard to open? Yes / No

Date of last physical exam? \_\_\_\_\_

Are you now under the care of your physician? If yes, condition being treated:

\_\_\_\_\_

Have you ever had any serious illness or operations? If yes, give details:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had an injury involving your face, head or neck: Yes / No

Do you have, or have you had any of the following:

Heart murmur, heart problems, heart surgery pacemaker Yes / No

Allergy to medication Yes / No

Are you currently taking medication Yes / No

Have you had serious trouble with your teeth or dental work? Yes / No

Rheumatic fever or rheumatic heart disease Yes / No

Vascular disease (High/Low blood pressure) Yes / No

Sinus trouble/Hay fever/Asthma Yes / No

Fainting spells or seizures Yes / No

Hepatitis/Jaundice/liver disease/mononucleosis Yes / No

Arthritis/Rheumatism/Kidney trouble Yes / No

Tuberculosis/persistent cough or coughing blood Yes / No

Syphillis/Gonorrhea or other venereal disease Yes / No

Do you have any blood disorder, such as anemia? Yes / No

Have you had surgery or radiation for any tumor or other condition  
of the mouth or lips Yes / No

AIDS or HIV positive? Yes/ No

Are you pregnant? Yes / No

Osteoporosis? If yes, which medication? Yes / No

Please add anything you feel is important or any other disease or problem not listed above:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Guardian: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_