

BARRY D. COHEN, D.D.S.



Member American Association of **Orthodontists**

Orthodontics for Adults & Children
Oro-facial Orthopedics
TM Dysfunction

TO OUR NEW PATIENTS:

Your kindness in furnishing the following information will be appreciated in preparing your child's clinical chart.

"Please Print"

Patients's Name _____ (Goes By) _____ Age: _____

Address _____ Male _____ Female _____ Date of Birth: _____

Home Phone () _____

E-Mail Address _____

Orthodontic Insurance Coverage? Yes _____ No _____ Secondary Insurance? Yes _____ No _____

Patient's Dentist _____ Patient Referred By _____

School _____

Names/ages of sisters and/or brothers treated here _____

Father's Name _____ Mother's Name _____

Social Security # _____ Social Security # _____

Date of Birth _____ Date of Birth _____

Address _____ Address _____

City _____ State _____ ZIP _____ City _____ State _____ ZIP _____

Phone: Home () _____ Phone: Home () _____

Business () _____ Business () _____

Cell/Pager () _____ Cell/Pager () _____

Employer _____ Employer _____

Occupation _____ Occupation _____

Parent's Marital Status _____ Is either parent deceased? _____

Father's Dentist _____ Mother's Dentist _____

Responsible party if different from above: _____ Nearest relative not living with you: _____

Name _____ Name _____

Social Security # _____ Address _____

Address _____

City _____ State _____ ZIP _____ City _____ State _____ ZIP _____

City _____ State _____ ZIP _____

MEDICAL HISTORY

1. Who is your child's physician? _____ Date of last physical exam? _____

Physician's Address _____ Physician's Phone No. _____

2. Has there been any change in your child's health within the past year? _____

3. Is your child being treated by a physician for any reason at present? _____

4. What medicine(s) is your child taking now? _____

5. Has your child ever been hospitalized for any illness, accident or surgery? _____

If yes, when and why? _____

Does your child have or has he/she had any of the following:	YES NO	
	(CHECK ✓)	
6. Heart Trouble (including heart murmurs, valve prosthesis/pacemaker)		
7. Rheumatic fever		
8. High/low blood pressure		
9. Kidney problems		
10. Liver disease (hepatitis)		
11. Jaundice		
12. Diabetes		
13. Anemia, Sickle Cell, Iron Deficiency, Etc.		
14. Prolonged bleeding		
15. Severe Infections		
16. Epilepsy		
17. Fainting		
18. Convulsions		
19. Pneumonia		
20. Tuberculosis		
21. Venereal Disease		

	YES	NO
22. Arthritis		
23. Allergy, hay fever, hives		
24. Asthma		
25. Sinus Problems		

Is your child allergic to or has he/she had any unusual reactions to:	YES NO UNKNOWN		
	YES	NO	UNKNOWN
26. Penicillin			
27. Dental local anesthetics			
28. Barbiturates			
29. Codeine or other narcotics			
30. Aspirin			
31. Sedatives			
32. Sulfa			
33. Any other drugs Medicines (Specify)			
34. Does your child have any other disease, condition or emotional problems you would like to bring to our attention?			

FURTHER INSIGHTS

How may we help you? Please tell us what you feel is your child's orthodontic problem.

How does your child feel about his/her facial appearance? _____

What is your child's reaction to orthodontic treatment and braces? _____

Has your child had any unfavorable dental experiences? _____

Please tell us about your child's interests and activities (sports, hobbies, music, school, etc.) _____

Does your child accept responsibility (making up room, caring for teeth, completing school assignments on time, caring for pet, helping with home chores)? _____

Please describe your child's individual character or nature (dependable, quiet, out-going, self-conscious, leader, sensitive, one of the group, motivated, etc.). _____

If you have any additional concerns, questions, or expectations you wish us to be aware of or you wish us to answer, please describe. _____

CHILD DENTAL HISTORY

What is your reason for bringing your child here? _____

1. Date of last dental visit _____
 2. Treatment at last visit _____

YES NO
 (CHECK ✓)

- 3. Has your child experienced any dental pain?
- 4. Has your child had an unhappy
 - a. medical visit
 - b. dental visit?
- 5. Any injuries to teeth, mouth or head?
- 6. Does your child have bleeding gums?
- 7. Does your child have frequent mouth ulcers or cold sores?
- 8. Did your child take a bottle to bed at nap or bed time?
- 9. Any oral habits: thumbsucking, nailbiting, mouthbreathing?

	YES (CHECK ✓)		NO

If yes, specify: _____

10. What is your child's attitude toward dentistry and/or orthodontics? _____

Additional comments _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

I give my consent for the initial examination at no charge. If diagnostic records are needed to determine the necessity of orthodontic treatment, I give my consent and accept responsibility for payment of records which will include x-rays, study models and photographs.

Signature _____ Date _____