Paul S. Burkey, D.D.S., M.S., P.C.
Orthodontic Specialist

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Building a community of great smiles.

Welcome to Our Office

Tell us about your child

Patient's name _____ (first / middle / last)
❑Male ❑Female
Nickname or preferred greeting_____Age_____Birthdate_____Home phone ( ) _____
Patient's home address _____City _____State_____Zip_____
School _____Grade _____ Height _____ Weight _____Birth weight _____
Birth mother's height_____Birth father's height _____

Dentist's name _____ Phone ( )_____City_____Date of last visit _____
Has the patient ever been seen by an orthodontist? ❑ yes ❑no If yes, please explain: _____
_____
Physician's name_____ Phone ( )_____City_____Date of last physical _____
Name of person(s) accompanying child today_____Relationship _____
Other family member(s) seen at our office _____
How did you hear about our office? _____
Why did you select our office? _____

Patient's Family

Mother's name_____❑Mrs. ❑Ms. ❑Dr. ❑Mother ❑Stepmother ❑Guardian
Address and home phone if different from above_____
Home phone ( )_____Occupation_____Employer_____
Bus. Phone ( )_____Cell phone/pager ( ) _____ E-mail _____

Father's name_____❑Mr. ❑Dr. ❑Rev. ❑Father ❑Stepfather ❑Guardian
Address and home phone if different from above_____
Home phone ( )_____Occupation_____Employer_____
Bus. Phone ( )_____Cell phone/pager ( ) _____ E-mail _____

Insurance Information

Any dental coverage? ❑Yes ❑No Any orthodontic coverage? ❑Yes ❑No
Primary policy holder's name_____Relationship _____
SS# _____-_____-_____Insurance company _____ Group/Policy # _____
Insured's employer_____
Secondary policy holder's name_____Relationship _____
SS# _____-_____-_____Insurance company _____ Group/Policy # _____
Insured's employer_____

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient Profile

❑ yes ❑ no ❑ dk/u Does patient follow directions well?
❑ yes ❑ no ❑ dk/u Does patient brush his/her teeth conscientiously?
❑ yes ❑ no ❑ dk/u Is patient sensitive or self-conscious about their teeth?
❑ yes ❑ no ❑ dk/u Does patient have learning disabilities or need extra help with instructions? Please explain:
_____
_____

Medical History

Now or in the past, has the patient had:

❑ yes ❑ no ❑ dk/u Asthma
❑ yes ❑ no ❑ dk/u Hayfever or hives
❑ yes ❑ no ❑ dk/u Frequent colds, sore throats, sinus trouble
❑ yes ❑ no ❑ dk/u Pneumonia, emphysema, bronchitis
❑ yes ❑ no ❑ dk/u Tuberculosis
❑ yes ❑ no ❑ dk/u Kidney problems
❑ yes ❑ no ❑ dk/u Endocrine or thyroid problems
❑ yes ❑ no ❑ dk/u Diabetes
❑ yes ❑ no ❑ dk/u High or low blood pressure
❑ yes ❑ no ❑ dk/u Anemia, excessive bruising or bleeding
❑ yes ❑ no ❑ dk/u Bone fractures, any major accidents
❑ yes ❑ no ❑ dk/u Hepatitis, jaundice or liver problem
❑ yes ❑ no ❑ dk/u History of eating disorder (anorexia, bulimia)
❑ yes ❑ no ❑ dk/u Stomach ulcer or hyperacidity
❑ yes ❑ no ❑ dk/u Rheumatoid or arthritic conditions
❑ yes ❑ no ❑ dk/u Eat a well-balanced diet

Please continue on reverse side

❑ yes ❑ no ❑ dk/u Polio, mononucleosis
❑ yes ❑ no ❑ dk/u Problems with the immune system
❑ yes ❑ no ❑ dk/u Vision, hearing or speech difficulties
❑ yes ❑ no ❑ dk/u Skin disorder
❑ yes ❑ no ❑ dk/u Cancer, tumor, radiation or chemotherapy
❑ yes ❑ no ❑ dk/u Aids, HIV positive
❑ yes ❑ no ❑ dk/u Heart problem (heart attack, arteriosclerosis, stroke, congenital heart defect, mitral valve prolapse, damaged or artificial heart valves, heart murmur or rheumatic heart disease)
❑ yes ❑ no ❑ dk/u Does the patient require antibiotic premedication before dental cleanings?
❑ yes ❑ no ❑ dk/u Does the patient currently have or ever had a substance abuse problem?
❑ yes ❑ no ❑ dk/u Allergies? If so, to what? _____
_____
❑ yes ❑ no ❑ dk/u Operations or hospitalizations? Describe: _____
_____
❑ yes ❑ no ❑ dk/u Being treated by another healthcare professional? For: _____
_____
❑ yes ❑ no ❑ dk/u Other physical problems or medical conditions? Describe: _____
_____

❑ yes ❑ no ❑ dk/u Frequent headaches
❑ yes ❑ no ❑ dk/u Birth defects or hereditary problems
❑ yes ❑ no ❑ dk/u Mental health disturbances or depression
❑ yes ❑ no ❑ dk/u ADD / ADHD
❑ yes ❑ no ❑ dk/u Sexually transmitted disease
❑ yes ❑ no ❑ dk/u Loss of weight recently, poor appetite

Any prescription medicine:

Medication: _____ Taken for: _____
Medication: _____ Taken for: _____
Medication: _____ Taken for: _____

Girls only:

❑ yes ❑ no ❑ dk/u Has the patient begun her period?
❑ yes ❑ no ❑ dk/u Is the patient currently pregnant?

Dental History

Now or in the past, has the patient had:

❑ yes ❑ no ❑ dk/u Primary (baby) teeth removed that were not loose
❑ yes ❑ no ❑ dk/u Permanent teeth removed
❑ yes ❑ no ❑ dk/u Any missing or extra permanent teeth
❑ yes ❑ no ❑ dk/u Started teething very early or late
❑ yes ❑ no ❑ dk/u Cysts or mouth infections
❑ yes ❑ no ❑ dk/u Bleeding gums when brushing teeth
❑ yes ❑ no ❑ dk/u Periodontal gum problems or treatment
❑ yes ❑ no ❑ dk/u Frequent canker sores or cold sores
❑ yes ❑ no ❑ dk/u History of speech problems or therapy
❑ yes ❑ no ❑ dk/u Teeth sensitive to hot or cold
❑ yes ❑ no ❑ dk/u Food impaction between teeth
❑ yes ❑ no ❑ dk/u Chipped or injured primary (baby) or permanent teeth? Please explain: _____
_____
_____
❑ yes ❑ no ❑ dk/u Injury to the face, chin or jaw? Please explain:
_____
_____

❑ yes ❑ no ❑ dk/u Any relative with similar tooth or jaw conditions
❑ yes ❑ no ❑ dk/u Concern about under or over developed jaw
❑ yes ❑ no ❑ dk/u Tooth grinding or clenching
❑ yes ❑ no ❑ dk/u Any pain in TMJ (jaw joint) around the ears
❑ yes ❑ no ❑ dk/u Any pain or soreness in the muscles of the face
❑ yes ❑ no ❑ dk/u Difficulty w/ chewing or jaw opening/locking
❑ yes ❑ no ❑ dk/u Mouth breathing, snoring or difficulty breathing
❑ yes ❑ no ❑ dk/u Abnormal swallowing habit (tongue thrusting)
❑ yes ❑ no ❑ dk/u Thumb/finger sucking habit? Until what age? _____
❑ yes ❑ no ❑ dk/u Aware of loose, broken or missing fillings
❑ yes ❑ no ❑ dk/u Is patient interested in having their teeth straightened?
❑ yes ❑ no ❑ dk/u Has the patient had any previous trouble with dental treatment? Please explain: _____
_____
_____
❑ yes ❑ no ❑ dk/u Any needed dental work (fillings, crowns, etc.) that is not completed? Please explain: _____
_____

What is your chief concern or reason for your visit today? _____
_____
_____

I have read and understood the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date signed: _____
(Parent or legal guardian)

Signed: _____ Date signed: _____
(Orthodontic staff member)