WILSON ORTHODONTICS

Dr. Dustin Wilson, DDS, MS
748 W Stadium Blvd, Suite 102
Jefferson City, MO 65109
Phone: 573-634-5122

CHILD ORTHODONTIC PATIENT QUESTIONNAIRE

Patient's name:_____ Preferred name:_____

Date of Birth:_____ Sex: M F SS#:_____

Address: Street:_____

City:_____ State:_____ Zip:_____ Telephone: (____)_____

Name of School:_____ Grade level:_____

Hobbies/Interests:_____

Name of responsible party:_____ Preferred name:_____

Address: Street:_____ City:_____

E-mail address:_____ Relationship to patient: _____

Home Phone:(____)_____Work Phone:(____)_____Cell Phone: (____)_____

Why are you and your child seeking orthodontic treatment? (Please be as specific as possible):

_____

Who may we thank for referring you to our office? _____

FAMILY STATUS

Father's name:_____ Cell phone: (____)_____

Occupation:_____ Employer:_____ Work Phone: (____)_____

Mother's name:_____ Cell phone: (____)_____

Occupation:_____ Employer:_____ Work Phone: (____)_____

Marital Status of parents:_____

INSURANCE INFORMATION Will you be using dental insurance? Yes No

Insurance company:_____ Group Number:_____

Telephone Number: (____)_____

Name of Subscriber: _____ Employer:_____

Employer Address: _____

Subscriber's Date of Birth_____ SS#_____

DENTAL HISTORY

General Dentist:_____ Phone:(____)_____

Address:_____

Date of last dental examination: _____

Has another member of the family had orthodontic treatment? Yes No Who? _____

Has this patient had a previous orthodontic consultation? Yes No Where/When?_____

_____

Has the patient ever had trauma/damage to the teeth, jaws, or gums? Yes No

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MEDICAL HISTORY

Family Physician:_____ Phone:(____)_____

Address:_____

Is the patient currently under a physician's care? Yes No

If yes, please explain _____

Is the patient taking any medications at this time? Yes No

If yes, please list _____

Is the patient allergic to any medications? Yes No

If yes, please list _____

Does the patient have any other allergies? Yes No

If yes, please list _____

Does the patient need to be premedicated (with antibiotics) for routine dental procedures? Yes No

If yes, please specify and give reason for this need: _____

Has the patient ever been hospitalized? Yes No

If yes, please explain _____

Females: Is the patient pregnant? Yes No

Does the patient have or has the patient ever had any of the following?

Yes	No		Yes	No		Yes	No	
□	□	AIDS/HIV+	□	□	Cold Sores	□	□	Injury to head
□	□	Anemia	□	□	Rheumatic Fever	□	□	Kidney Disease
□	□	Arthritis	□	□	Diabetes	□	□	Lung Disease
□	□	Asthma	□	□	Epilepsy/Seizures	□	□	Previous Surgery
□	□	Oral Ulcers	□	□	Hearing Problem	□	□	Psychological Therapy
□	□	Birth Defects	□	□	Heart Condition	□	□	Radiation or cancer therapy
□	□	Bleeding Disorder	□	□	Speech Therapy	□	□	Tonsils/Adenoid Surgery
□	□	Cerebral Palsy	□	□	Hepatitis	□	□	Injury to face/teeth/gums

Do you have any disease, condition, syndrome, or problem not listed above?

Please explain:_____

DOES/DID THE PATIENT:

Grind his/her teeth at night? Yes No Brush his/her teeth □ Often □ Occasionally □ Reluctantly

Suck thumb, finger, pacifier? Yes No If yes, what age was the habit discontinued?_____

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT

Is the patient aware of the need for orthodontic treatment? Yes No

The patient's interest in having treatment is: □ Excited □ Willing if necessary □ Reluctant

BEHAVIOR ASSESSMENT Personality (check any that apply):

□ Calm □ Nervous □ Quiet □ Shy □ Outgoing □ Cooperative □ Uncooperative
□ Confident □ Afraid □ Emotional disturbance

GROWTH STATUS (To help us determine remaining growth potential of the jaws and facial structures)

Height:_____ Weight:_____

Females: Has the patient started her menstruation? Yes No If yes, what age?_____

Males: Has the patient yet undergone voice changes? Yes No Facial hair growth? Yes No

Signature of the person completing this form_____

Relationship to the patient:_____ Today's Date:_____

Thanks for your help. We're excited to get to know you better!