



dobie+rollins
ORTHODONTICS

Hamden & Guilford Locations

(203) 288 – 0900

www.dr-orthodontics.com

PATIENT INFORMATION *for* CHILD

Date: _____

Child's Name: _____ Nickname: _____ Gender: _____

Date of Birth: _____ Age: _____ School: _____ Grade: _____

Child's Hobbies: _____

Has anyone in your family been treated in our office? _____

Please list all sibling(s) & age(s): _____

Please CIRCLE how you would you like to receive appointment reminders: Email Text Message Both

Parent / Guardian

Name: _____

Marital Status: _____

Address: _____

Cell #: _____

Home #: _____

Email: _____

Date of Birth: _____

Social Security #: _____

Occupation/Employer: _____

Parent / Guardian

Name: _____

Marital Status: _____

Address: _____

Cell #: _____

Home #: _____

Email: _____

Date of Birth: _____

Social Security #: _____

Occupation/Employer: _____

Responsible Party Name: _____

How did you find us? Dentist Google Search Invisalign Website Social Media Friend: _____

Are you on Facebook? Yes No Please join us @ www.facebook.com/DRorthodontics

Are you on Instagram? Yes No Please join us @ DRorthodontics

GROWTH ASSESSMENT

Has the patient grown in the last year? Yes No How much: _____

Child's height: _____ Mother's height: _____ Father's height: _____

Has the patient's shoe sized changed recently? Yes No How much: _____

Has the patient reached puberty? Yes No



MEDICAL HISTORY

Please Circle All Conditions That Apply:

Heart abnormality
Rheumatic/Scarlet fever
Artificial Heart Valve
High/Low Blood Pressure
Kidney/Liver problems
Bleeding Abnormality
Sickle Cell Anemia
Tuberculosis

Diabetes
HIV/AIDS
Hepatitis
Bronchitis
Asthma
Thyroid Disorder
Bone Disorder
Artificial Joints

Cancer/Tumor
GI Disorder
Epilepsy/Seizures
Autism
Cleft Lip/Palate
Birth Defect(s)
Growth Disorder
Tonsils/Adenoids removed

Hearing Impairment
Speech Disorder
Fainting/Dizziness
Nervous/Anxious
Tactile Defensive
Major Surgery
Currently Pregnant
NONE

If circled, please explain: _____

Condition not listed: _____

Any allergies? Yes No Please explain: _____

Any medications? Yes No Please explain: _____

DENTAL HISTORY

Dentist's Name: _____

Last Dental Visit: _____

Any previous orthodontic consults? Yes No If so when: _____

Any previous orthodontic treatment? Yes No Please explain: _____

Main orthodontic concern: _____

Prior facial/dental injuries: _____

Oral habits (e.g. sucking thumb): _____ Until age: _____

TMJ problems (clicking or pain): _____

Excessive grinding/clenching: _____ Mouth breathing: _____

Tongue Thrusting: _____ Missing or extra permanent teeth: _____

Any family history of jaw/orthognathic surgery: _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the practice of any medical or dental changes to this record.

Parent / Guardian Signature: _____ Date: _____

OFFICE USE ONLY

Right: Class I Class II _____ Class III _____ X-B _____

Left: Class I Class II _____ Class III _____ X-B _____

OJ: _____ OB: _____ Deep _____ Open _____

Upper: Crowding _____ Spacing _____

Lower: Crowding _____ Spacing _____

Other: _____

OH: _____ Recall: _____ Ins: _____

Tx Plan: _____

Est. Fee: _____ Est. Time: _____