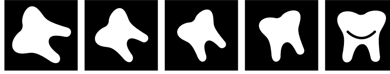
Dr. Lori Landreneau



orthodontics

Member
American Association of
Orthodontists

Date: ____________________

Name______________________________ Phone #______________ Age-years _____mos._____ Date of Birth_____/ _____/ ________

Mailing Address______________________________________City____________________ State __________ Zip __________

School/Work ______________________ Work Phone #__________________ Grade_______ Quality of School Work: A B C D F

Patient's/Parents Family Status: Mar. Sep. Div. Wid. Patient's Relationship: Birth Adoption Sex: M F

Father/Husband/Legal Guardian____ Phone ________________________

Home Address ____

E-mail ____

Employed By: ____ Occupation ______________________________

Business Phone # ______________________________________

Mother/Wife/Legal Guardian____ Phone ________________________

Home Address ____

E-mail ____

Employed By____ Occupation ______________________________

Business Phone # ______________________________________

Who is responsible for making decisions concerning patient's treatment? ______________ _Who is responsible for account? ________________

Insurance______________ Policyholder's Social Security Number__________________ Policyholder's date of birth______________

Reason for seeking treatment____

Patient cooperation will be: Good Fair Poor

Other Family members with similar problems?____

Has any member of your family received orthodontic treatment?_______Name________________ Name of Orthodontist ________________

Has patient seen another orthodontist? _______ Name ____

Has the patient had previous orthodontics? _______ Date ________________ Name of Orthodontist __________________________

Whom may we thank for referring you? ____

MEDICAL AND DENTAL HISTORY:

Patient's Dentist ____ Phone # ____

Last Exam date ____

Patient's physician ____ Phone # ____

☐ Yes ☐ No Is the patient in good heath?

Has the patient ever been treated for any illness? (Please indicate with Yes or No beside each of the following.)

___ Diabetes	___ Pneumonia	___ Hepatitis	___ Venereal Disease	___ Liver Involvement
___ Anemia	___ Epilepsy	___ Nervous Disorder	___ Bone Disorders	___ Endocrine Problems
___ Asthma	___ Kidney Trouble	___ Rheumatic Fever	___ Prolonged Bleeding	___ Fainting/Dizziness
___ Pain in Jaw/TMJ	___ Heart Trouble or Murmur	___ Migraines	___ Digestive Disorders	___ Sinus Disorders

___ Other Illnesses? ____

___ Operations (List with dates) ____

☐ Yes ☐ No Any allergies or drug sensitivity? ____

☐ Yes ☐ No Any medications being taken? What and Why?____

☐ Yes ☐ No Has the patient reached puberty? Girls – Started Menstruating (Appox. Date) _______ Boys--Voice Change (Approx. Date)_______________

☐ Yes ☐ No Has there been any injury to the face, mouth or teeth? When? ____

☐ Yes ☐ No Has the patient ever sucked his/her thumb or finger? What age? ______________________________________

☐ Yes ☐ No Does the patient have any speech problems? ____

☐ Yes ☐ No Is the patient a mouth breather? While awake? ______________________ While asleep? ______________________

☐ Yes ☐ No Have you been informed of any missing or extra permanent teeth? _____________________________________

☐ Yes ☐ No Does the patient play any musical instrument? What?____

List patient hobbies____

Who has completed this form ____ Relationship to patient ______________________________

Signature ____ Print Name ____