myKIDSdds
Dentistry and Orthodontics for Children

8325 Walnut Hill Lane Suite 111, Dallas, TX 75231 (214-696-3082) www.mykidsdds.com

Patient Information

Full Name ____________________ Date of Birth __________ SS #__________

Primary Home Address ______________________________Phone # __________

Secondary Home Address (if applicable)______________________________Phone # __________

If patient is a minor, parent's or guardians name______________________________

Patients hobbies, pets, toys, or pastimes ______________________________

Siblings and their ages______________________________

If patient is an adult, names and ages of children ______________________________

Whom may we thank for referring you to our office?______________________________

If a member of your family is now an orthodontic patient at this office please list their name______________________________

Have you or any member of your family *ever* been a patient in this office? Please list name:______________________________

Patient's Dentist, address, and phone #:______________________________Date of last visit:__________

Is this you or your child's first visit to an orthodontist?__________If not please share with us why you wish to make a change. __________

Please discuss your concerns and desires regarding you/or your child's orthodontic care. ______________________________

Does your child have a history of any oral habits? (Mouth breathing, Thumb sucking, Etc.)__________If so please explain:__________

1. Are you (or your child) having jaw pain or discomfort at this time?... .... YES NO

2. Do you (or your child) feel nervous about having orthodontic treatment?... .... YES NO

3. Have you (or your child) been admitted to the hospital during the past two years?... .... YES NO

4. Have you (or your child) been under the care of a medical doctor during the past two years?... .... YES NO

Physician's Name______________________________ Phone # __________

5. What medicine or drugs are you (or your child)currently taking or have you taken during the past two years?... .... YES NO

If yes, please list: ______________________________

6. Are you aware of being allergic to or have you ever reacted adversely to any medication, product, or material?.......... YES NO

If yes, please list: ______________________________

7. Is there any information you can share that will aid us in treating you (or your child)? ______________________________

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in you chest, or shortness of breath, or because you are very tired? Y N

9. Do your ankles swell during the day? .... Y N

10. Do you use more than 2 pillows to sleep? .... Y N

11. Have you lost or gained more than 10 pounds in the past year? .... Y N

12. Do you ever wake up from sleep short of breath? .... Y N

13. Are you on a special diet? .... Y N

14. Indicate which of the following you have had or have presently. Circle "yes" or "no" to each item.

Adenoids Removed...	YES NO	Cosmetic Surgery...	YES NO	Kidney Problems...	YES NO
AIDS...	YES NO	Diabetes...	YES NO	Liver Disease...	YES NO
Allergies or Hives...	YES NO	Drug Addiction...	YES NO	Mental Health Problems...	YES NO
Anemia...	YES NO	Emphysema...	YES NO	Mononucleosis...	YES NO
Angina Pectoris...	YES NO	Endrocrine Disorders...	YES NO	Nervousness...	YES NO
Anorexia/Bulimia...	YES NO	Epilepsy or Seizures...	YES NO	Pneumonia...	YES NO
Arthritis...	YES NO	Fainting or Dizzy Spells...	YES NO	Polio...	YES NO
Artifical Heart Valve...	YES NO	Fever Blisters...	YES NO	Pregnant...	YES NO
Asthma...	YES NO	Glaucoma...	YES NO	Rheumatic Fever...	YES NO
ADD or ADHD...	YES NO	Hay Fever...	YES NO	Rheumatism...	YES NO
Birth Defects or Hereditary Problems...	YES NO	Hearing Loss...	YES NO	Scarlet Fever...	
		Heart Pacemaker...	YES NO	Seizures...	YES NO
Blood Pressure High/Low.	YES NO	Heart Surgery...	YES NO	Sickle Cell Disease...	YES NO
Blood Transfusion ...	YES NO	Heart Trouble...	YES NO	Sinus Trouble...	YES NO
Bruise Easily...	YES NO	Hemophillia...	YES NO	Skin Disorder...	YES NO
Chemotherapy...	YES NO	Hepatitis A...	YES NO	Speech Difficulties...	YES NO
Cold Sores...	YES NO	Hepatitis B...	YES NO	Stroke...	YES NO
Congential Heart Lesions.	YES NO	Immune System Problems...	YES NO	Substance Abuse...	YES NO
Cortisone Medicine...	YES NO	Jaundice or Liver Problems...	YES NO	Thumb Sucker...	YES NO

15. Do you have any disease, condition, or problem not listed?... .... YES NO

If yes please describe____

Responsible Party Information

Full Name ____________________________________ Married Divorced Partnership Seperated Single Widowed

Social Security # ____________________ Date of Birth ________________ Relationship to Patient ______________

Home Address ____ How Long?__________ yrs.

Previous Address (if less that 3 yrs.) ____

Employer ____________________ How Long?__________ yrs. Email Address ____________________

Home phone ____________________ Cell Phone ____________________ Work phone ____________________

Spouse's Full Name ____________________________________ Married Divorced Partnership Seperated Single Widowed

Social Security # ____________________ Date of Birth ________________ Relationship to Patient ______________

Home Address ____ How Long? __________yrs.

Employer ____________________ How Long? __________ yrs. Email Address ____________________

Home phone ____________________ Cell Phone ____________________ Work Phone____________________

Emergency Information

Name of nearest relative not living with you ____

Complete Address ____

Phone ______________________________ Relationship ______________________________

I have read and understood the above questions. 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. If there are any changes later to this history record or medical/dental status, I will inform this practice.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with ______________________ (patient name) and further authorize and consent that Doctor choose and employ such assistance as deemed fit. Bureau reports may be obtained.

Signature (Legal Parent or Guardian if minor)____