BURLINGAME
ORTHODONTICS, PLLC

CONFIDENTIAL

PATIENT INFORMATION FOR PATIENTS UNDER AGE 18

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname/Prefer to be Called _____ Birthdate_____ Social Security #_____ Sex: ☐M ☐F

School _____ Sports/Hobbies _____

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

Have any other family members been treated in our office? Please name them. _____

PARENT/GUARDIAN INFORMATION

Patient lives with (check all that apply) ☐mother ☐father ☐stepmother ☐stepfather ☐grandparents ☐other: _____

Parent(s)/Guardian(s) Full Name(s) _____

Relationship to Patient _____

Mailing Address _____
Street City Zip

Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

If more than one address:

Parent(s)/Guardian(s) Full Name(s) _____

Relationship to Patient _____

Mailing Address _____
Street City Zip

Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you_____

Complete address _____
Street City Zip

Phone _____

MEDICAL HISTORY

Primary Care Physician _____ Date of Last Visit _____
City, State _____ Phone _____

Other physician being seen now _____ Date of Last Visit _____
City, State _____ Phone _____
Reason _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No Is the patient allergic to anything else? (*latex, metals, foods)* _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Has the patient seen a physician in the last 12 months (other than routine physical)? _____
Yes No Has the patient ever taken bisphosphonates? Oral or IV? _____
Female Patients only:
Yes No Has menstruation started? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Dizziness/Fainting	Hepatitis/Liver problems	Neurological Disorders
Anemia	Endocrine or thyroid problems	Herpes	Pneumonia
Arthritis/Joint Problems	Epilepsy	High Blood Pressure	Prolonged Bleeding
Asthma or Hayfever	Gastrointestinal Disorders	History of Eating Disorder	Radiation/Chemotherapy
Birth Defects	Head/Neck/Face Injuries	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart murmur	Immune system problems	Tuberculosis
Diabetes	Heart problems	Kidney problems	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
City, State _____ Phone _____

Other dentist/dental specialist _____ Date of Last Visit _____
City, State _____ Phone _____
Reason _____

What concerns you most about your child's teeth? _____

What concerns your child most about his/her teeth? _____

Has you child received any previous orthodontic treatment? _____

Any previous orthodontic consultations? _____

DENTAL HISTORY [continued]

Yes No Is the patient presently in any dental pain? _____

Yes No Ever experienced any unfavorable reaction to dentistry? _____

Yes No Has the patient ever chipped any teeth? _____

Yes No Has the patient ever had any teeth removed by the dentist? _____

Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____

Yes No Has the patient ever had speech problems or speech therapy? _____

Yes No Have there been any injuries to face, mouth, or teeth? _____

Yes No Is any part of your mouth sensitive to temperature or pressure? Where? _____

Yes No Do gums bleed when brushing? _____

Yes No Any type of thumb or tongue habit? _____

Yes No Does the patient have trouble breathing through his/her nose? _____

Yes No Experience jaw clicking or popping? _____

Yes No Aware of clenching or grinding teeth during the day? _____

Yes No Experience “tension” headaches? _____

Yes No Has the patient ever been treated for TMD problems? _____

Yes No Is the patient sensitive or self-conscious about his/her teeth? _____

Yes No Does the patient smoke or chew tobacco? _____

RELEASE AND WAIVER

I authorize release of any information regarding my child’s orthodontic treatment to my child’s medical and/or dental professionals and my medical and/or dental insurance company.

Parent/Guardian Signature: _____ Date: _____

I have read the above questions and understand them. I have truthfully answered the above questions and agree to inform this office of any changes in my medical or dental history. I will not hold my orthodontist or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

Parent/Guardian Signature: _____ Date: _____

I authorize Dr. Burlingame to perform a complete orthodontic evaluation on my child including any necessary photos and radiographs.

Parent/Guardian Signature: _____ Date: _____

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Date_____

Patient's name _____
Last First Middle

Birthdate_____

DENTAL INSURANCE INFORMATION

Primary Coverage:

Policy Holder's Full Name_____ Birthdate _____ Relationship to patient _____

Insured's Social Security # _____ Insured's Employer _____

Insurance Company_____ Group # _____ ID # _____

Insurance Co. Address_____ Phone No._____

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

If Additional Coverage:

Policy Holder's Full Name_____ Birthdate _____ Relationship to patient _____

Insured's Social Security # _____ Insured's Employer _____

Insurance Company_____ Group # _____ ID # _____

Insurance Co. Address_____ Phone No._____

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

If Additional Coverage:

Policy Holder's Full Name_____ Birthdate _____ Relationship to patient _____

Insured's Social Security # _____ Insured's Employer _____

Insurance Company_____ Group # _____ ID # _____

Insurance Co. Address_____ Phone No._____

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know