NUMBER:


Dr. Steve Astuto | Orthodontics of Amarillo, Inc. www.amazingortho.com | 7901 SW 45th Avenue 806.359.1683 | Amarillo, Texas 79119 800.749.1683


DATE:__________

## 1. PATIENT INFORMATION BEGIN HERE:

Name:______________________________ ______________________ Address:______________________
First MI Last Nickname

Phone:______________ Birthday:____________ Age:____ Sex:____ City:______________ State:____ Zip:__________

## 2. RESPONSIBLE PARTY INFORMATION:

### RESPONSIBLE PARTY #1

Name:______________________________
First MI Last

Address:______________________________

City:______________ State:______ Zip:__________

Home Phone:______________ Cell Phone:______________

Birthday:______________ Work Phone:______________

Age:__________ Sex:__________ Marital Status:__________

S.S. #:______________________________

**EMPLOYER INFORMATION**

Name:______________________________

Address:______________________________

City:______________ State:______ Zip:__________

**INSURANCE COMPANY INFORMATION**

Name:______________________________

Address:______________________________

City:______________ State:______ Zip:__________

Insurance Phone:______________ Ext:__________

Group #:______________ Local or Union #:__________

### RESPONSIBLE PARTY #2

Name:______________________________
First MI Last

Address:______________________________

City:______________ State:______ Zip:__________

Home Phone:______________ Cell Phone:______________

Birthday:______________ Work Phone:______________

Age:__________ Sex:__________ Marital Status:__________

S.S. #:______________________________

**EMPLOYER INFORMATION**

Name:______________________________

Address:______________________________

City:______________ State:______ Zip:__________

**INSURANCE COMPANY INFORMATION**

Name:______________________________

Address:______________________________

City:______________ State:______ Zip:__________

Insurance Phone:______________ Ext:__________

Group #:______________ Local or Union #:__________

## 3. E-MAIL ADDRESS: ______________________________

## 4. Authorization for Consumer Credit Report: YES ☐ NO ☐

Dentist Name:______________________________

Emergency Contact:______________________________

Other Children Treated in our Office Please List:______________________________

______________________________

Referred By:______________________________

# 5. MEDICAL INFORMATION:

**Do you have or have you ever had:**

| | YES | NO |
|---|---|---|
| Any Heart Disease: | | |
| Any Respiratory Disease: | | |
| Any Blood Disease: | | |
| Any Liver Disease: | | |
| Any Thyroid Disease: | | |
| Any Kidney Disease: | | |
| H.I.V. Positive: | | |
| Any Intestinal Disease: | | |
| Any Bone Disease: | | |
| Any Nervous/Emotional Problems: | | |
| Any High or Low Blood Pressure: | | |
| Any Endocrine Problems: | | |
| Any Problem with Wounds Healing: | | |
| Any Tumors or Cancer: | | |

| | YES | NO |
|---|---|---|
| Rheumatic/Yellow/Scarlet Fever: | | |
| Acquired Immune Deficiency Syndrome: | | |
| Is the Patient under Medical Care: | | |
| Rheumatism or Arthritis: | | |
| A History of Fainting or Dizziness: | | |
| Does the Patient have a Drug Addiction: | | |
| Is the Patient Pregnant at this Time: | | |
| Measles/Mumps/Chicken Pox: | | |
| Does the Patient Smoke: | | |
| Has the Patient ever had Fever Blisters: | | |
| Has the Patient had a Physical this Year: | | |
| Has the Patient Reached Puberty: | | |

| | YES | NO |
|---|---|---|
| Heart Murmur: | | |
| Mononucleosis: | | |
| Hepatitis: | | |
| Polio: | | |
| Diabetes: | | |
| Anemia: | | |
| Hemophilia: | | |
| Emphysema: | | |
| Epilepsy: | | |

| | YES | NO |
|---|---|---|
| Asthma or Hay Fever: | | |
| Tuberculosis: | | |
| Any Broken Bones: | | |
| Prolonged Bleeding: | | |
| Yellow Jaundice: | | |
| Radiation Therapy: | | |
| Chemical Therapy: | | |
| Blood Transfusion: | | |
| Is the Patient in Good Health: | | |
| Is Height and Weight Normal for Age: | | |

Is the Patient Allergic to Anything: YES ☐ NO ☐

If Yes, What: ______________________________

List any Medication: ______________________________

Are you aware of any other disease, condition or problem not listed above that we should know about:

If Yes, What: ______________________________

# 6. DENTAL HISTORY:

| | Yes | No |
|---|---|---|
| Has the Patient Seen a General Dentist in the Last Year: | | |
| Any Pain, Clicking or Discomfort In or Near the Ears: | | |
| Has the Mouth, Face or Teeth Been Injured by a Fall or Accident: | | |
| Have You Been Informed of Missing or Extra Permanent Teeth: | | |
| Are You Aware of Any "GUM" Problems: | | |
| Has a Physician or Dentist Advised Antibiotics Before a Dental Exam: | | |
| Have the Patient's Tonsils or Adenoids Been Removed: | | |
| Do You Feel the Patient can Benefit From Orthodontic Treatment: | | |
| Is the Patient Happy with Their "SMILE": | | |
| Does the Patient Want to Improve Their "SMILE" and "BITE": | | |
| Would the Patient Mind Wearing "BRACES": | | |

Does the Patient Have or Ever Had Any of the Following Habits:

| | Yes | No |
|---|---|---|
| Cheek, Tongue or Lip Chewing: | | |
| Thumb Sucking: | | |
| Mouth Breathing: | | |
| Finger Nail Biting: | | |

| | Yes | No |
|---|---|---|
| Clenching Teeth: | | |
| Tongue Thrusting: | | |
| Grind Teeth: | | |
| Speech Problems: | | |

| | | |
|---|---|---|
| Has the Patient Been Examined by an Orthodontist Before: | | |
| If Yes, When: | | |
| Have Other Members of the Family had Orthodontic Treatment: | | |
| If Yes, Were You Happy with the Results: | | |

If No, Why: ______________________________

In Your Own Words What is the Orthodontic Problem: ______________________________

What Would You Like the Orthodontic Treatment To Accomplish: ______________________________

______________________________ Parent or Responsible Party Signature

______________________________ Date