James E. Martinez, D.D.S., Inc..
Specialist in Orthodontics
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Cypress, Texas 77429
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www.cypressbraces.com

Diplomate of the American Board of Orthodontics
Member of the American Association of Orthodontists, Southwestern Society of Orthodontists, & World Federation of Orthodontists

Date: _____

PATIENT INFORMATION (Child / Adolescent)

Patient's Name: _____

Age: _____ Birth date: _____ Sex: _____

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: (Father)_____(Mother)_____

Father's Name: _____ Employer: _____ Phone: (W) _____ Years: ____

Mother's Name: _____Employer: _____ Phone: (W) _____ Years: ____

Patient living with (please circle): MOTHER FATHER SELF OTHER_____

School: _____ Grade: _____

Name of Siblings (and ages of each):_____

Special interest of the patient: _____

Chief concern regarding the patient's teeth: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____ SSN_____

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____Work Phone: _____

Is patient covered by insurance for orthodontic treatment? YES NO - If yes, please fill out the following:

Insurance co. name_____ Insured's name_____

Insurance co. address_____ Relationship to patient_____

Insurance co. phone_____ Insured's birthday_____

Group #_____ Insured's employer_____

Insured's ID# or SS#_____

PERSON TO BE CONTACTED IF PATIENT / PARENT CANNOT BE REACHED

Name: _____ Relation: _____

Address: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

MISCELLANEOUS

Family Dentist: _____

Family Physician: _____

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

I hereby certify that all information on this form is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in medical status. I also understand that all information on this form is held in the strictest confidence.

Signature (parent of minor):_____ Date: _____

Patient Name_____ **Date**_____

PATIENT MEDICAL HISTORY (Child / Adolescent)

Is patient in good health? ..... Yes No
Does patient have any history of major illness? ..... Yes No
Has patient ever been under the care
of a physician for illness?..... Yes No
Please explain any pertinent medical history
_____
_____
_____

Does patient wear contact lenses? ..... Yes No
Does patient gag easily? ..... Yes No

Patient: Height_____ Weight_____
Father: Height_____
Mother: Height_____

CHECK ANY OF THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED

Please indicate with (Y) Yes or (N) No

Y	N		Y	N		Y	N		Y	N	
__	__	Heart problems	__	__	Glaucoma	__	__	Hepatitis or Liver problems	__	__	Sinus Problems
__	__	High blood pressure	__	__	Pneumonia	__	__	Kidney Problems	__	__	Stroke
__	__	Low blood pressure	__	__	Tuberculosis	__	__	Measles	__	__	Typhoid Fever
__	__	Circulatory problems	__	__	Epilepsy	__	__	Mumps	__	__	Tonsillitis
__	__	Nervous disorders	__	__	Arthritis	__	__	Psychiatric Care	__	__	Endocrine problems
__	__	Radiation Treatments	__	__	Asthma	__	__	Rheumatic Fever	__	__	Ulcers
__	__	Excessive Bleeding or Anemia	__	__	Diabetes	__	__	Scarlet Fever	__	__	HIV / AIDS
						__	__	Malignancies	__	__	Other _____

__ __ Currently pregnant? If yes, how many months? _____

List any allergies: _____
What medications are now being taken? Please give reasons:_____
_____
_____

Does patient have a tendency to colds? Yes_____ No_____ Sore throats? Yes_____ No_____ Ear infections? Yes_____ No_____
Have tonsils and adenoids been removed? Yes_____ No_____ What age? _____
Date of last physical exam? _____

PATIENT DENTAL HISTORY

Date of last dental exam? _____ Last dental cleaning? _____ Yes No
Have there ever been any injuries to the face, mouth or teeth? ……..… _____ _____
Has patient ever sucked fingers or thumb? Until what age?…… _____ _____
Does patient have any speech problems? …… _____ _____
Does patient grind teeth? While awake……...…… _____ _____
While asleep…… _____ _____
Is patient a mouth breather? While awake……..…… _____ _____
While asleep…… _____ _____
Has patient been informed of any missing or extra permanent teeth? …… _____ _____
Has patient consulted an orthodontist previously? ……..…… _____ _____
Did either parent have orthodontic treatment? ..... _____ _____
Does patient have pain in the jaw joints? ……..…… _____ _____
Right_____ Left_____
Does patient have popping or cracking of the jaw joints? …… _____ _____
Right_____ Left_____
When did this begin? _____
Does patient have headaches? _____ Frequency_____ Location _____

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Signature (parent of minor):_____ Date: _____