BOZEK
ORTHODONTICS

John Bozek
Ray Bozek

Date: ______________
Day / Month / Year

## PATIENT INFORMATION

Name: ______________________ Sex: ______ Birth Date: ______________ Age: ________

Address: ____________________________________________

Home Telephone: ______________________ Business Telephone: ______________________

School: ______________________ Grade: ________ Patient Lives With: ______________

Mother Name: ______________________ Address/Phone: ______________________

Fathers Name: ______________________ Address/Phone: ______________________

Responsible Party: ______________________ Address/Phone: ______________________

M.D: ______________ Dentist: ______________ Referral: ______________ Ins: ______________

Chief Complaint: ____________________________________________

## MEDICAL HISTORY

Any Serious Illnesses or Recent Hospitalizations: ______________________

Allergies or Drug Sensitivities: ______________________

Medications Used: ______________________

Does the patient require additional antibiotics for dental treatment? Yes ☐ No ☐ ______________

**Do you have or have you ever had any of the following?**

Heart Murmur? Yes ☐ No ☐ ______________ Rheumatic Fever? Yes ☐ No ☐ ______________

Heart Disorder? Yes ☐ No ☐ ______________ Blood Disorder? Yes ☐ No ☐ ______________

Asthma ? Yes ☐ No ☐ ______________ Respiratory Disorders? Yes ☐ No ☐ ______________

Endocrine Disorders? Yes ☐ No ☐ ______________ Diabetes? Yes ☐ No ☐ ______________

Epilepsy/Seizures? Yes ☐ No ☐ ______________ Mental Illness? Yes ☐ No ☐ ______________

Kidney Disorders Yes ☐ No ☐ ______________ Liver Disorders or Hepatitis Yes ☐ No ☐ ______________

Immunocompromising Disorder? Yes ☐ No ☐ ______________

Others? Yes ☐ No ☐ ______________

## DENTAL HISTORY

Last Dental visit ______________________ X-Rays ______________

Dental Problems? ie. cavities, gum disease, bleeding upon brushing, pain Yes☐ No☐ ______________

Any Teeth ever moved or lost? Yes☐ No☐ ______________

Any Trauma to teeth or jaws? Yes☐ No☐ ______________

Habits? ie. Finger, thumb, lip biting Yes☐ No☐ ______________

Does the patient breathe through their mouth? Yes☐ No☐ ______________

Difficulty with speech or chewing? Yes☐ No☐ ______________

Previous orthodontic treatment or consultations? Yes☐ No☐ ______________

Have any other members of the family ever had orthodontic treatment Yes☐ No☐ ______________

Is the patient concerned over the appearance of their teeth? Yes☐ No☐ ______________

Is the patient ever teased about their teeth? Yes☐ No☐ ______________

Any orthodontic fears or concerns? Yes☐ No☐ ______________

TMD – click, pops, grinding, headaches, or earaches? Yes☐ No☐ ______________

____________________________________________

**To help determine you child's growth potential**

Has the patient reached puberty? Yes☐ No☐ ______________

Does the patient look more like Mom or Dad? Yes☐ No☐ ______________

Does the patient have any siblings? Yes☐ No☐ ______________

Ages and resembles to siblings? Yes☐ No☐ ______________

Signature of patient or guardian ______________________ Date ______________