LAWTON ORTHODONTICS

Brett T. Lawton, DMD, MS
Thomas C. Lawton, DMD, MS

201 N. Lakemont Avenue
Winter Park, FL 32792
407.644.8242

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

American Association of Orthodontists

2984 Alafaya Trail
Oviedo, FL 32765
407.644.8242

Medical and Dental Information For Minor Child

Patient's Last Name_____First_____Middle_____Nickname_____

Date of Birth____/____/____ Sex: ☐ M ☐ F Age in Years_____School_____Grade_____

Home Address: _____ _____ _____ _____ How Long?_____
STREET CITY STATE ZIP

Home Phone_____Patient Resides With_____

Father's Name_____SS#_____

Address (if different from above) _____

Father's Cell (____)_____Work Phone (____)_____E-Mail_____

Father's Occupation_____Employer_____How Long?_____

Mother's Name_____SS#_____

Address (if different from above)_____

Mother's Cell (____)_____Work Phone (____)_____E-Mail_____

Mother's Occupation_____Employer_____How Long?_____

Person Responsible for Account/Relationship to Patient_____

Address (if different from above): _____ _____ _____ _____
STREET CITY STATE ZIP

Phone and SS# (if different from above) Home (____)_____Work (____)_____SS#_____

Orthodontic Insurance? Yes ☐ No ☐

Name of Insured_____Date of Birth____/____/____SS#_____

Name of Insurance Company_____ID#_____

Address_____ Phone (____)_____

WHOM MAY WE THANK FOR THIS REFERRAL?_____

Medical History

The patient's Medical and Dental History Information is very important. This information bears directly on the outcome of treatment and is also important in helping to avoid complications. Thank you for taking the time to answer these questions.

1. Is the patient in good health? ..... ☐ Yes ☐ No
2. Name and address of patient's physician (Name)_____(City)_____
3. Patient's last physical examination was on_____
4. Is the patient under the care of a physician? ..... ☐ Yes ☐ No
   If so what is the condition begin treated_____
5. Is the patient taking any medicine(s), including nonprescription medicine? ..... ☐ Yes ☐ No
   If so, what medicine(s) is being taken?_____
6. Has patient had any serious illness, operation, or been hospitalized in the past 5 years ..... ☐ Yes ☐ No
   If so what was the illness or problem?_____
7. Have tonsils been removed ..... ☐ Yes ☐ No
8. Have adenoids been removed ..... ☐ Yes ☐ No
9. Has patient had any other surgery. Please specify:_____
10. Has patient had any injury to the face, head or teeth? ..... ☐ Yes ☐ No
    If yes, please indicate dates(s) of occurrence and nature of injury:_____

11. Is patient adopted ☐ Yes ☐ No

12. Does patient have, or has patient had, any of the following diseases or problems?

- A. Damaged heart valves or artificial heart valves, *including heart murmur or rheumatic heart disease, scarlet fever, artificial joints*? ☐ Yes ☐ No
- B. Cardiovascular disease (*heart trouble, heart attack, angina, coronary insufficiency, coronary inclusion, arteriosclerosis, stroke*) ☐ Yes ☐ No
- C. High blood pressure ☐ Yes ☐ No
- D. Low blood pressure. ☐ Yes ☐ No
- E. Environmental allergies hayfever, etc. ☐ Yes ☐ No
- F. Sinus trouble ☐ Yes ☐ No
- G. Asthma ☐ Yes ☐ No
- H. Fainting spells or seizures, dizziness ☐ Yes ☐ No
- I. Diabetes ☐ Yes ☐ No
- J. Hepatitis jaundice or liver disease ☐ Yes ☐ No
- K. AIDS, HIV infection or positive HIV test ☐ Yes ☐ No
- I. Thyroid problems ☐ Yes ☐ No
- M. Respiratory problems, emphysema, bronchitis, etc.? ☐ Yes ☐ No
- N. Arthritis or painful swollen joints? ☐ Yes ☐ No
- O. Stomach ulcer or hyperacidity? ☐ Yes ☐ No
- P. Kidney trouble ☐ Yes ☐ No
- Q. Epilepsy or other neurological disease? ☐ Yes ☐ No
- R. Sexually transmitted disease ☐ Yes ☐ No

13. Does patient have any blood disorder, such as anemia, hemophilia, leukemia, sickle cell disease ☐ Yes ☐ No

14. Is the patient allergic or has patient had a reaction to:

- A. Local anesthetics ☐ Yes ☐ No
- B. Penicillin or other antibiotics ☐ Yes ☐ No
  Please specify_____
- C. Latex or any other allergies ☐ Yes ☐ No
  Please specify_____

15. Has patient had any unfavorable experience in a dental or medical office? ☐ Yes ☐ No
If so explain_____

16. Does patient have any disease, condition, or problem not listed above that you think we should know about? ☐ Yes ☐ No
If so explain_____

17. Onset of puberty: (Boys- Voice changed); (Girls - started menstruation) ☐ Yes ☐ No

Dental information

1. When was patients last dental visit?_____
2. The name and address of patient's dentist is (Name)_____(City)_____
3. I would describe patient's temperament as: _____
4. Patient's hobbies or sports interests are: _____
5. Does the patient play a musical instrument? If so what? _____ ☐ Yes ☐ No
6. Is patient a mouth breather? ☐ Yes ☐ No
7. Does the patient have any history of thumbsucking, fingersucking, lip biting, nail biting? ☐ Yes ☐ No
   If so please indicate which history and if it has continued or has stopped _____
8. Would patient mind wearing braces? ☐ Yes ☐ No
9. Has patient ever had orthodontic treatment (braces)? ☐ Yes ☐ No
10. Has patient ever had orthodontic examination, evaluation, conference or consultation? ☐ Yes ☐ No
11. Has patient ever been told to see an orthodontist? ☐ Yes ☐ No
12. Will patient follow instructions regarding good oral hygiene? ☐ Yes ☐ No
13. Does patient's jaw joint(s) click, crack, pop, grate or make any other sound(s)? ☐ Yes ☐ No
14. Does patient grind or clench teeth? ☐ Yes ☐ No
15. Has patient's jaw ever "locked" open or closed? ☐ Yes ☐ No
16. Has patient ever been told that patient has TMJ or "Jaw Joint" problems? ☐ Yes ☐ No

Please answer the following:

1. Present Height_____ Weight_____ Number of Brothers and Sisters_____ Have any of them received orthodontic treatment? ☐ Yes ☐ No
2. If we have previously treated another child or family member, please give the members name(s)_____
3. In your own words, what is the problem?_____

The medical/dental information provided is complete and correct to the best of my knowledge. I agree to inform this office of any changes(s). I understand that, where appropriate, credit bureau reports maybe obtained. Thank you for your cooperation. The above information is important in your diagnosis and treatment, and will be kept in strict confidence.

Signature_____ Date_____

PARENT OR GUARDIAN