annapolis
ORTHODONTICS

Dr. Julie Langguth
Dr. Edwin Berkinshaw

PATIENT INFORMATION

Patient Name: _____ Date: _____

General Dentist: _____ Birth Date: _____ Age: _____ Gender: _____

PARENT INFORMATION

Father's Name: _____ Birth Date: _____

Address: _____

Job Title: _____ Employer: _____

Work Phone: _____ Work Email: _____

Mother's Name: _____ Birth Date: _____

Address: _____

Job Title: _____ Employer: _____

Work Phone: _____ Work Email: _____

Patient Resides With: Both Parents _____ Mother _____ Father _____ Other _____

BEST CONTACT INFORMATION

Name: _____ Relationship: _____ Best Number: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: _____ Address: _____

ORTHODONTIC INSURANCE INFORMATION

Primary Insurance Company

Name: _____ ID Number:_____ Birth date:_____

Employer:_____

Secondary Insurance Company

Name: _____ ID Number:_____ Birth date:_____

Employer:_____

HEALTH HISTORY:

Please indicate if the patient has or had the following:

- Allergies/Asthma
- Previous orthodontic treatment
- Heart Murmur
- Heart Disease
- Hepatitis
- Tongue Tie
- Frequent Stuffed Nose
- Sleep Apnea
- Behavioral Problems
- Pregnant
- Rheumatic Fever
- Mouth Breather
- Thumb or Finger Sucking Habit
- Bleeding Disorder
- Epilepsy
- Frequent Headaches
- Drug Sensitivities
- Osteoporosis/Osteopenia

Does the patient have any special problems not listed above?_____

Did patient breastfeed? _____ For how long? _____ Any difficulty nursing? _____

Does the patient have any jaw clicking when opening or closing?_____

Has the patient been under the care of a physician in the past two years other than routine checks? _____

_____

Is the patient currently taking any medications?_____

Is the patient actively growing?_____

Patient's physical development resembles: Father _____ Mother _____ Both _____ Neither _____

Father's Height _____ Mother's Height _____

Has the patient reached puberty? Yes _____ No _____

Females: has menstruation begun? Yes _____ No _____ At what age? _____ Month/Year ____ / ____

AIRWAY EVALUATION

Please Indicate if the patient has any of the following:

	Never	Occasionally	Frequently
Difficulty breathing when asleep	○	○	○
Stops breathing during sleep	○	○	○
Snores	○	○	○
Restless sleep	○	○	○
Excessive movement during sleep	○	○	○
Daytime sleepiness	○	○	○
Daytime Hyperactivity (ADD/ADHD)	○	○	○
Teeth grinding	○	○	○
Bed wetting	○	○	○
Acid reflux	○	○	○
Chews with mouth open	○	○	○
Daytime breathing through mouth	○	○	○
Lips apart during the day	○	○	○
Dark circles under eyes	○	○	○

I agree to allow Annapolis Orthodontics to use images taken of my child before, during and after treatment for education/training purposes.

Signature: _____ Relationship: _____ Date: _____