11 Park Street
Leominster, MA 01453
(978) 537-6100

Patient Information

Patient's Name____ Patient's DOB:________
Last First MI Nickname

Give parents' names:

(Mother) ______________________ **(Father)**______________________

Address______________________ School ______________Grade _______

Home Phone: ____________________ I provide consent to Dr. Todd Rowe to use my cell phone number to (Choose one or both) □ call or □ text regarding appointments. I also give consent for Dr. Todd Rowe to call my cell phone regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is ____________________ ________ (initial)

Siblings:Name______________________Age_____Name______________________ Age_____

Siblings:Name______________________Age_____Name______________________ Age_____

Name of patient's dentist: ______________________

Date of last dental visit ______________________

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

Main reason for orthodontic consultation/treatment: ______________________

____

What one area of Dental-Orthodontic treatment concerns you most?

Quality **Cost** **Discomfort** **Time**

Commitments that limit appointment availability: ______________________

How does the patient feel about the possibility of orthodontic treatment?

Excited **Neutral** **Nervous/Anxious** **Not Interested in Treatment**

Please complete both sides of this form

Dental History

Has the patient had prior orthodontic treatment or consultation? _____yes_____no Orthodontist?__________________

Have there been injuries to the face, mouth, or teeth? _____yes _____no Describe ____________________

Has the patient ever experienced jaw joint pain/discomfort? _____yes _____no Describe ______________________

Has the patient had treatment for jaw joint problems? _____yes _____ no Describe ______________________

Does the patient have any missing or extra permanent teeth? _____yes ______no Describe_____________________

Medical History

Name of patient's physician ___________________________________Date of last medical visit ____________

Is the patient in good health? _____yes _____no

Is patient currently being treated by a physician? _____yes _____no

Please circle all that apply:

Allergies, Asthma or Hay fever	Fainting spells or seizures	Diabetes
Hepatitis, Jaundice or Liver disease	Blood disorder or anemia	Arthritis
Heart Murmur or other heart condition	Tuberculosis	**Latex Allergy**

Any other medical problems? ____

Is the patient taking any medications? ______yes _____no If so, what?__________________

Is the patient allergic or sensitive to any medications? ______yes _____no If so, what?__________________

Is the patient taking vitamins? ______yes _____no

Is the patient using fluoride? ______yes _____no

Are antibiotics required before dental treatment? ______yes _____no

Could the patient be pregnant? ______yes _____no

Does the patient have chronic ear pain or infections? ______yes _____no

Does the patient have any speech problems? ______yes _____no

Is the patient a mouth breather? ______yes _____no

Does the patient grind or clench his/her teeth? ______yes _____no

Does the patient have a thumb or finger habit? ______yes _____no

Signature ____ Date ________________

Staff Review ____

Please complete both sides of this form