XCELERATED ORTHODONTICS
of Portsmouth

WELCOME TO OUR OFFICE

DATE_____
Updated _____
Updated _____

PATIENT'S NAME_____**NICKNAME**_____

D.O.B._____ AGE_____ SEX M_____ F_____

ADDRESS_____ TOWN_____ STATE_____ ZIP_____

HOME PHONE:_____ Cell/WorkPHONE_____

EMAIL_____

PARENT/GUARDIAN FULL NAME_____

HOME ADDRESS _____ TOWN_____ STATE_____ ZIP_____

OCCUPATION _____ EMPLOYED BY_____

HOME PHONE: _____ Cell/Work PHONE _____

EMAIL_____

PARENT/GUARDIAN FULL NAME_____

HOME ADDRESS _____ TOWN_____ STATE_____ ZIP_____

OCCUPATION _____ EMPLOYED BY_____

HOME PHONE: _____ Cell/Work PHONE _____

EMAIL_____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

GENERAL APRAISAL

WHO CAN WE THANK FOR YOUR REFERRAL? _____

CHIEF COMPLAINT (REASON FOR CONSULTATION)_____

HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT? _____NO _____YES

IF YES, EXPLAIN_____

DOES PATIENT'S PROBLEM RESEMBLE _____FATHER _____MOTHER _____SIBLINGS

OTHER CHILDREN IN FAMILY	AGE	SEX	HAD ORTHO TREATMENT	NEEDS ORTHO TREATMENT
_____	____	____	_____	_____
_____	____	____	_____	_____

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MEDICAL HISTORY

PHYSICIAN/PEDIATRICIAN _____ LAST EXAM _____

CURRENTLY UNDER MEDICAL TREATMENT ____NO YES___ explain _____
HISTORY OF RECENT ILLNESS ____NO YES___ explain_____
CURRENTLY TAKING MEDICATION ____NO YES___ explain _____
EVER BEEN HOSPITALIZED ____NO YES___ explain_____
EVER HAD AN OPERATION ____NO YES___ explain _____
ALLERGIC TO MEDICATIONS ____NO YES___ explain _____
ANY OTHER ALLERGIES ____NO YES___ explain _____
ONSET OF PUBERTY
BOYS - HAS HIS VOICE CHANGED? ___NO ___YES WHEN_____
GIRLS - HAS MENSTRUATION BEGUN? ___NO ___YES WHEN_____

DOES PATIENT HAVE A HISTORY OF:

____ANEMIA ____BONE DISORDERS _____EPILEPSY ____ASTHMA
____KIDNEY DISORDERS _____RHEUMATIC FEVER
____DIABETES ____LIVER INVOLVEMENT _____BLEEDING

PROBLEMS:

____HEART ____FAINTING OR DIZZINESS
_____ENDOCRINE DISORDERS

EXPLAIN _____

DENTAL HISTORY

DENTIST/PEDODONTIST_____ LAST EXAM_____

___ THUMB/FINGER SUCKING UNTIL AGE _____
___ MOUTHBREATHING _____AWAKE _____ASLEEP
___ GRINDING OR CLENCHING ____DAY ____NIGHT
___ NAIL-BITING
___ LIP BITING/LICKING
___ BLEEDING GUMS
___ INJURIES TO FACE/MOUTH/TEETH
___ SORENESS OR CLICKING IN JOINT ____NO ____YES

HOW FREQUENTLY DO YOU USE FLOSS _____

HAVE YOU BEEN INFORMED OF ANY EXTRA OR MISSING TEETH? _____

ANY FURTHER COMMENTS: