PATIENT INFORMATION SHEET – YOUTH

Patient Name: ______________________________ Gender: ______________

Preferred Name: ____________________ Patient's Birthdate: _____/_____/_____ Age: _______
month / day / year

Patient's Address: ____

Patient's Home Phone #: (_____) _____ - _______

Patient's Cell Phone #: (_____) _____ - _______ Carrier (ex. Fido, Rogers): ____________________

Patient's E-mail address: __________________________School:____________________________

For monitoring purposes, are there any siblings that may require orthodontic treatment now or in the future?

Sibling Name: ________________________ Birthdate _____/_____/_____ Same address Y / N

Sibling Name: ________________________ Birthdate _____/_____/_____ Same address Y / N

Sibling Name: ________________________ Birthdate _____/_____/_____ Same address Y / N

Name of primary caregiver: ________________________ ***Circle one***: (Mother, Father, Step-Parent, Other)

Address same as patient's above? Yes ____ No ____ If No: ______________________________

Cell Phone #: (_____) _____ - _______ Carrier (ex. Fido, Rogers): ____________________

Home Phone #: (_____) _____-_______

Work Phone #: (____) _____-______ E-mail address____________________________________

Name of secondary caregiver: ________________________ ***Circle one***: (Mother, Father, Step-Parent, Other)

Address same as patient's above? Yes ____ No ____ If No: ______________________________

Cell Phone #: (_____) _____ - _______ Carrier (ex. Fido, Rogers): ____________________

Home Phone #: (_____) _____-________

Work Phone#: (_____) _____-______ E-mail address: ______________________________

Name of additional caregiver: ________________________ ***Circle one***: (Mother, Father, Step-Parent, Other)

Address same as patient's above? Yes ____ No ____ If No: ______________________________

Cell Phone #: (_____) _____ - _______ Carrier (ex. Fido, Rogers): ____________________

Home Phone #: (_____) _____-_______

Work Phone #: (____) _____-______ E-mail address____________________________________

We send an email/text message reminding you of your appointment. Please indicate the main cell phone (with carrier) and email address for your reminders.

Cell phone: ______________________________ ***Carrier*** (ex. Fido, Rogers): __________

Email: ____

We would like to call your insurance company prior to your appointment to provide you with the most accurate and up-to-date information possible.

Do you have Dental Insurance? ***Yes / No***

Primary Insurance

Name of Subscriber ______________________________ Date of Birth____________________

Insurance Company __________________Group#________________Certificate#______________

Secondary Insurance

Name of Subscriber ______________________________ Date of Birth____________________

Insurance Company __________________Group#________________Certificate#______________

Medical History

Does the patient:

Have allergies? Yes____ No ____ If yes, what type? ____________________

Have any conditions that affect the immune system (AIDS, HIV, Leukemia)? Y N

Bruise easily after injury? Y N

Experience prolonged bleeding after injury? Y N

Has the patient ever had:

Surgery with general anesthetic	Y	N	If yes, what type? ____________		
Rheumatic fever	Y	N	Diabetes	Y	N
Chronic kidney problems	Y	N	Heart problems	Y	N
Lung problems	Y	N	Liver problems	Y	N
Epilepsy	Y	N	Cerebral palsy	Y	N
Abnormal bleeding problems	Y	N	Prosthetic joint	Y	N
Bronchitis	Y	N	Head/ear aches	Y	N

Please list any medications used regularly: ____________________

Any other medical information/dental-related concerns you would like us to know about? ____________________

____

Dental History

What are the main concerns regarding the patient's teeth? ____________________

____

Who is the family dentist? ____________________

How did you hear about our office? (Please circle all that apply): Friend or Family (Name: ____________)

Google Social Media (Facebook, Instagram, etc) Internet Search Dentist Referral

Advertisement Doctor Locator on Invisalign Website Other

Does the patient:

Want orthodontic treatment?	Y	N	
Brush his/her teeth daily?	Y	N	How often: ____________
See a general dentist regularly?	Y	N	Last visit: ____________
Play a musical instrument?	Y	N	What type: ____________

Have any of the following habits?

Thumb sucking	Y	N
Grinding teeth at night	Y	N
Nail biting	Y	N
Mouth breathing (eg. mouth open when reading/watching TV)	Y	N
Snoring	Y	N

Has the patient:

Ever had previous orthodontic consultations/treatment?	Y	N	
Ever had problems with sore gums?	Y	N	
Ever received a severe blow to the teeth or jaws?	Y	N	
Ever had speech therapy?	Y	N	If yes, how old was the patient? _____

I, ________________________________ ([Circle one]: Mother, Father, Patient, Guardian), give permission to allow Dr. Dueckman and Dr. Felty (and/or staff) to report any findings to my dentist or any other dental professional as they deem necessary.

Signature:____ Date: _______________________