RIVERSTONE
—ORTHODONTICS—

MICHAEL P. CHAFFEE, D.D.S., M.S.
Specialist in Orthodontics

Member
American Association of
Orthodontists

PATIENT INFORMATION FORM

Date of Exam: ____________

Patient's Name: ____
First Middle Last

Date of Birth: __________ Age: ______ Sex: M/F Home Phone: ____________

Home Address: ____ Cell Phone: ____________
Street City Zip

School: ____ Grade: ____________

Patient's Dentist: ____________ Referred by: ____________ Physician: ____________

Names and ages of other children in family: ____

____

Marital Status of Parents: ☐Single ☐Married ☐Separated ☐Divorced ☐Remarried ☐Widowed

Patient Lives With: ☐Both Parents ☐Mother ☐Father ☐Guardian ____________

Father's Name: ____________ Employer: ____________ Business Ph: ____________

Mother's Name: ____________ Employer: ____________ Business Ph: ____________

Hobbies, sports, and interests of patient: ____________ Favorite Music: ____________

MEDICAL HISTORY

Have you ever been treated for any of the following?

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Hay Fever	☐	☐	Hormonal Imbalances	☐	☐
Heart Trouble	☐	☐	Asthma	☐	☐	Liver Problems/Hepatitis	☐	☐
Rheumatic Fever	☐	☐	Allergies	☐	☐	Prolonged Bleeding	☐	☐
Bone Disorders	☐	☐	Convulsions	☐	☐	Endocrine/Thyroid	☐	☐
Cancer	☐	☐	Arthritis	☐	☐	HIV/AIDS	☐	☐
Kidney Problems	☐	☐	Tuberculosis	☐	☐	Cleft Lip or Palate	☐	☐

Any other medical concerns? .... ☐ ☐

List any drugs or medications now being taken ____________

Is the patient allergic to any drugs or medications? ______ If yes, list medication ____________

Amount of growth in last 6 months: ______ Has the patient reached puberty? *(Growth Stage Indicator)*.......... ☐ ☐

Height : Patient: ______ Mother: ______ Father: ______ Patient most resembles: ☐ Mother ☐ Father ☐ Adopted

Does patient wear contact lenses? .... ☐ ☐

Have tonsils and adenoids been removed? ______ If yes, at what age? ______

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth?.................... ☐ ☐

Did/does the patient ever suck thumb or fingers? ______ If yes, until what age? ______

Does the patient breathe predominantly through the mouth?.................... ☐ ☐

Does the patient play a wind musical instrument? ______ If yes, what kind? ____________

Does the patient have speech problems?.................... ☐ ☐

Has the patient been informed of any missing or extra permanent teeth?.................... ☐ ☐

Have wisdom teeth been removed? ______ If yes, at what age? ______

Has the patient had any discomfort or clicking in the jaw joints near ears?.................... ☐ ☐

Does the patient clench or grind his/her teeth? .... ☐ ☐

Does the patient have frequent head or neck aches? .... ☐ ☐

Does the patient have pain or ringing in the ears? .... ☐ ☐

Has the patient's jaw ever locked or slipped out of place? .... ☐ ☐

Are his/her teeth sore or sensitive?.................... ☐ ☐

When did the patient last have a checkup/cleaning at the dentist? ______ Any work remaining?.......... ☐ ☐

What is the patient/parent's primary concern? *(Facial appearance, crooked teeth, etc.)* ____________

Has the patient had any previous orthodontic examinations? ______ If yes, when? ____________

Is the patient especially apprehensive toward dental visits?.................... ☐ ☐

Does the patient want orthodontic treatment? .... ☐ ☐

This form was completed by: ____________

____
Signature *(Parent's signature if patient is a minor)*