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Peabody, MA 01960
Phone: (978) 535-5353
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Pavlo Orthodontics
We change your smile... You change the world!

1 Harris Street, Suite 1
Newburyport, MA 01950
Phone: (978) 463-5353
Fax: (978) 465-1910

www.pavlobraces.com

CHILD HISTORY
PATIENT INFORMATION/CLINICAL HISTORY *(please complete in ink)*

Name _____ Age _____ Sex_____ Birthdate____/____/_____
Last First MI

Home address_____ Home ph#_____

City _____ State_____ Zip_____

How long residing at current address? _____ Patient's E-mail address_____

School_____ Grade_____

Best telephone to call ***during business hours***_____ Cell phone_____

Patient's Family Dentist_____ Last visit_____

Patient's Family Physician_____

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

Please describe why you have sought this consultation:_____

_____

Who is responsible for the account? ___ Mother ___ Father ___Guardian

Mother's Information: ___Married ___Divorced ___Single ___Guardian ___Widowed

Name_____Birthdate____/____/_____
Last First MI

Home address_____ Home ph#_____

City _____State_____ Zip_____Cell ph#_____

E-mail address _____SS#_____

Employer_____Work ph#_____

Does Mother have Orthodontic Insurance? ___Yes ___No How long employed with current employer? _____

Name of Insurance Company _____State_____

ID#_____ Group, plan or Policy#_____

Father's Information: ___Married ___Divorced ___Single ___Guardian ___Widowed

Name_____Birthdate____/____/_____
Last First MI

Home address_____ Home ph#_____

City _____State_____ Zip_____Cell ph#_____

E-mail address _____SS#_____

Employer_____Work ph#_____

Does Father have Orthodontic Insurance? ___Yes ___No How long employed with current employer? _____

Name of Insurance Company _____State_____

ID#_____ Group, plan or Policy#_____

If responsible party is other than the patient's parent, please give information:

Name_____SS#_____ Relationship _____

Address _____ Tel# _____

Does responsible party have Orthodontic Insurance? ___Yes ___No

Name of Insurance Company _____State_____

ID#_____ Group, plan or Policy#_____

MEDICAL HISTORY: Have you had or do you have any of the following?

Y / N	Mitral Valve Prolapse	Y / N	Scarlet Fever	Y / N	Congenital Heart Defect	Y / N	Heart Murmur
Y / N	Rheumatic Fever	Y / N	High Blood Pressure	Y / N	Hemophilia	Y / N	Blood Disorder
Y / N	AIDS/HIV Infection	Y / N	Hepatitis	Y / N	**Allergies (latex, nickel, plastic)**	Y / N	Diabetes
Y / N	Herpes (Any type)	Y / N	ADD/ADHD	Y / N	Hearing Impairment	Y / N	Artificial joints
Y / N	Arthritis	Y / N	Epilepsy	Y / N	Mental Health Problems	Y / N	Headaches
Y / N	Sleep Apnea	Y / N	Cancer				

Please list any other significant information regarding the patient's medical history:

_____

_____

Y / N Is the patient currently under a physician's care? If yes, reason _____

Y / N Is the patient currently taking any medication? If yes, describe _____

Y / N Is the patient allergic to any medications? (aspirin, penicillin, etc.) If yes, what? _____

Y / N Have there been any injuries to the face, teeth or mouth? If yes, describe _____

Y / N Has there been any surgery in the head and neck area? If yes, describe _____

Y / N Has the patient ever had general anesthesia? When? _____

Y / N Does the patient need to be pre-medicated before dental work?

DENTAL HISTORY:

Y / N Do you brush daily?

Y / N Do you floss daily?

Y / N Do any of your teeth hurt? If yes, upper or lower, right or left?_____

Y / N Have you had any previous orthodontic treatment? If yes, when and with whom _____

Y / N Have there been any injuries to your mouth or teeth? If yes, describe_____

Y / N Have you ever fallen or bumped your chin? If yes, describe_____

Y / N Has your jaw ever popped or clicked? If yes, describe_____

Y / N Do you clench or grind your teeth? If yes, when?_____

Y / N Does it hurt to chew?_____

Y / N Have you experienced any problems with previous dental treatment?_____

Y / N Do you play a musical instrument?_____

Do you have any of the following habits?

Y / N	Finger/Thumbsucking	Y / N	Nail biting	Y / N	Ice chewing	Y / N	Gum chewing
Y / N	Lip biting/sucking	Y / N	Mouth Breather				

GROWTH AND DEVELOPMENT:

Y / N Girls-Has monthly cycle started yet? If so, when?_____

Y / N Boys-Has voice changed, yet? If so, when?_____

Y / N Are there any learning disabilities? If yes, explain_____

Y / N Are there other children in the family? Names and ages:_____

_____

Y / N Has any other family member had orthodontic treatment?_____

Y / N Has any other family member been a patient in this practice?_____

Any further information you can provide concerning your child is greatly appreciated. The more we know about each patient, the more helpful we can be in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies:

_____

_____

I understand that the above medical and dental information is correct to the best of my knowledge. If there are later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____

Signature of Responsible Adult Date

_____

Doctor's Signature Date