Appalachian Orthodontics of Lynchburg
Dr. Elena Black

SleepWellness Associates of Lynchburg
Elena Black, DDS, PhD

CHILD INFORMATION

TODAY'S DATE _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

Nickname: _____ Birthdate: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

School: _____ Grade: _____

Siblings and Age: _____

PARENTS/GUARDIANS INFORMATION

Parent/Guardian 1 (circle one) Last Name: _____ First Name: _____

Social Security#: _____ Birthdate: ____/____/ _____

Address: _____ City: _____ Zip Code: _____

Occupation/Employer: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Relationship to Patient: ❑ Biological ❑ Step ❑ Adopted ❑ Foster ❑ Other: _____

_____

Parent/Guardian 2 (circle one) Last Name: _____ First Name: _____

Social Security#: _____ Birthdate: ____/____/ _____

Address: _____ City: _____ Zip Code: _____

Occupation/Employer: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Relationship to Patient: ❑ Biological ❑ Step ❑ Adopted ❑ Foster ❑ Other: _____

_____

Parents Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widow/Widower

Patient Lives With (check all that apply): ❑ Mother ❑ Father ❑ Grandparent ❑ Stepmother ❑ Stepfather ❑ Other:

FINANCIAL RESPONSIBILITY

Individual Responsible For This Account: _____ Relationship To Patient: _____

Address: _____ City: _____ Zip Code: _____

Best Number To Be Reached At: _____ Birthdate: ____/____/ _____

DENTAL INSURANCE

Is the patient covered by dental insurance or medical assistance? ❑ Yes ❑ No

Primary Insurance Company: _____

Primary Insured: Last Name: _____ First Name: _____ SSN: _____

Address: _____ City: _____ Zip Code: _____

Occupation/Employer: _____

Initials: _____

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DENTAL HISTORY

Explain the nature of the problem in your own terms. Why do you think you may benefit from orthodontic treatment?

_____

_____

Whom may we thank for referring you to our office?

_____

Who suggested you might benefit from orthodontic treatment?

❑ Your Dentist ❑ A Family Member ❑ A Friend ❑ The School ❑ Other

Were you aware of any orthodontic problems prior to the referral? _____

Have you ever had orthodontic treatment? ❑ Yes ❑ No If so, when? _____

_____

_____

Name of your dentist _____

Last visit to dentist was on _____ for _____

Dentist's Address _____

_____

Do you grind or clench your teeth? ❑ Yes ❑ No

Does your jaw "click, crack or pop" upon opening or closing? ❑ Yes ❑ No

Do you have pain in the lower jaw upon opening or closing? ❑ Yes ❑ No

Do you have TMJ dysfunction? ❑ Yes ❑ No

Have you ever had any speech problems or any speech therapy? ❑ Yes ❑ No

Have you had any medical problems associated with dental treatment before? ❑ Yes ❑ No

Have you ever had any trauma to your mouth/teeth/face? ❑ Yes ❑ No

Do you primarily breathe through your mouth? ❑ Yes ❑ No

Do you snore? ❑ Yes ❑ No

Do your brush your teeth daily? ❑ Yes ❑ No

Do you floss daily? ❑ Yes ❑ No

Does the patient's physician recommend medication for a preexisting condition before any dental procedure? ❑ Yes ❑ No

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Medical Questionnaire

Patient's Physician: _____

Address: _____

Patient's general health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Please list any and all previous illnesses, hospitalizations or serious medical conditions: _____

_____

Please list any **allergies**:

_____

Is your child currently taking any medications (pills, drugs, injections, etc.)? Please list them here:

_____

Has the patient ever taken intravenous bisphosphonates such as: Zometa, Aredia or Didronel? ❑ Yes ❑ No

Has the patient ever taken oral bisphosphonates such as: Fosamax, Actonel, Boniva, Skelid or Didronel? ❑ Yes ❑ No

Has the patient ever taken other bone antiresorptive medication? ❑ Yes ❑ No If yes, check all that apply:

❑ Denosumab (Prolia®) ❑ Calcitonin (Miacalcin®, Fortical®) ❑ Teriparatide (Forteo) ❑ Raloxifene (Evista®)

If female, has menstruation begun? ❑ Yes ❑ No If yes, when? _____

If female, is the patient pregnant or is there any possibility they might be pregnant? ❑ Yes ❑ No

Does the patient presently have or have they **ever had** any of the following?

Anemia ❑ Yes ❑ No	Epilepsy/Seizures/Fainting spells ❑ Yes ❑ No	Kidney Disease ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No	Frequent Headaches ❑ Yes ❑ No	Liver Disease ❑ Yes ❑ No
Artificial bone/joints ❑ Yes ❑ No	Gonorrhea ❑ Yes ❑ No	Mitral Valve Prolapse ❑ Yes ❑ No
Adenoids/Tonsils Removed ❑ Yes ❑ No	Hay Fever ❑ Yes ❑ No	Pneumonia ❑ Yes ❑ No
Asthma ❑ Yes ❑ No	Heart Disease ❑ Yes ❑ No	Psychiatric/Learning Disability ❑ Yes ❑ No
AIDS or HIV+ ❑ Yes ❑ No	Heart Murmur ❑ Yes ❑ No	Rheumatic Fever ❑ Yes ❑ No
Blood Disorders ❑ Yes ❑ No	Hemophilia/ Abnormal Bleeding ❑ Yes ❑ No	Sinus/Breathing Problems ❑ Yes ❑ No
High/Low Blood Pressure ❑ Yes ❑ No	Herpes ❑ Yes ❑ No	Stroke ❑ Yes ❑ No
Cancer/Chemotherapy/Radiation ❑ Yes ❑ No	Hepatitis ❑ Yes ❑ No	Syphilis ❑ Yes ❑ No
Cold Sores ❑ Yes ❑ No	Hives ❑ Yes ❑ No	Tuberculosis/TB ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No	Jaundice ❑ Yes ❑ No	Venereal Disease ❑ Yes ❑ No
		Other _____

Does the patient's physician recommend medication for a preexisting condition before any dental procedure? ❑ Yes ❑ No

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Does the patient have any of the following problems regularly (once a week or more) during sleep?

PROBLEM			If Yes, Age of Onset	Days per Week
Snoring or Noisy Breathing	❑ Yes	❑ No		
Choking and Gasping in Sleep	❑ Yes	❑ No		
Stopping Breathing	❑ Yes	❑ No		
Struggling to Breathe	❑ Yes	❑ No		
Mouth Breathing/ Trouble Breathing Through Nose	❑ Yes	❑ No		
Difficulty Swallowing/ Drooling	❑ Yes	❑ No		
Restless Sleep / Tossing and Turning	❑ Yes	❑ No		
Frequent Leg Movements	❑ Yes	❑ No		
Teeth Grinding	❑ Yes	❑ No		
Sleep Walking	❑ Yes	❑ No		
Body Rocking/ Head Banging	❑ Yes	❑ No		
Awakening Frightened / Screaming	❑ Yes	❑ No		
Bed Wetting	❑ Yes	❑ No		
Night Sweating	❑ Yes	❑ No		

AUTHORIZATIONS

I authorize the release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

I certify that the above information is accurate and understand that an appropriate credit bureau report may be obtained.

I have read the above questions and understand them. I will not hold my child's orthodontist or any member of her team responsible for any errors or omissions that I have made in the completion of this form.

I will notify my child's orthodontist of any changes in their medical or dental history.

Signature: _____ Date: _____