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CHILD ORTHODONTIC PATIENT QUESTIONNAIRE

Patient's name: _____ Preferred name: _____

Date of Birth: _____ Sex: M F E-mail address: _____

Address: Street: _____ City: _____

State: _____ Zip: _____ Home Telephone: () _____

Name of School: _____ Grade level: _____

Hobbies/Interests: _____

Name of responsible party: _____ Preferred name: _____

Address: Street: _____ City: _____

E-mail address: _____ Home Telephone: () _____

Work Telephone: () _____ Cell Phone: () _____

Why are you and your child seeking orthodontic treatment? (Please be as specific as possible):

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

FAMILY STATUS

Father's name: _____ Cell phone: () _____

Occupation: _____ Employer: _____

Work Phone() _____

Mother's name: _____ Cell phone: () _____

Occupation: _____ Employer: _____

Work Phone() _____

Marital Status of parents: _____ Is the patient adopted? Yes No

INSURANCE INFORMATION Will you be using dental insurance? Yes No

Insurance company: _____ Group Number: _____

Telephone Number: () _____

Name of Subscriber: _____ Employer: _____

Subscriber's Date of Birth _____ SS# _____

DENTAL HISTORY

General Dentist: _____ Phone: () _____

Address: _____

Date of last dental examination: _____

Has another member of the family had orthodontic treatment Yes No Who? _____

Has this patient had a previous orthodontic consultation? Yes No

MEDICAL HISTORY

Family Physician: _____ Phone (____) _____

Address: _____

Is the patient currently under a physician's care? Yes No

If yes, please explain _____

Is the patient taking any medicine at this time? Yes No

If yes, please list _____

Is the patient allergic to any medications? Yes No If yes, please list _____

Does the patient have any other allergies? Yes No If yes, please list _____

Does the patient need to be premedicated (with antibiotics) for routine dental procedures? Yes No

If yes, please specify and give reason for this need: _____

Has the patient ever been hospitalized? Yes No If yes, please explain _____

Females: Is the patient pregnant? Yes No

Does the patient have or has the patient ever had any of the following?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Injury to head
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Oral Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Radiation or cancer therapy
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils/Adenoid Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Injury to face/teeth/gums

Does the patient have any disease, condition, or problem not listed above? Please explain:

DOES/DID THE PATIENT:

Grind his/her teeth at night? Yes No Brush his/her teeth Often Occasionally Reluctantly

Suck thumb, finger, pacifier? Yes No If yes, what age was the habit discontinued? _____

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT

Is the patient aware of the problem? Yes No

The patient's interest in having treatment is: Excited Willing if necessary Reluctant

BEHAVIOR ASSESMENT

Personality (check any that apply):

- Calm Nervous Quiet Shy Outgoing Uncooperative Cooperative Confident
- Afraid Emotional disturbance

Progress at school when compared to children of the same age:

- Behind Same Level Advanced

GROWTH STATUS:

Height: _____ Weight: _____

Females: Has the patient started her menstruation? Yes No If yes, what age? _____

Males: Has the patient yet undergone voice changes? Yes No Facial hair growth? Yes No

Thanks for your help. We're excited to get to know you better!

Signature of the person completing this form: _____

Relationship to the patient: _____ Today's Date: _____