OWENS ORTHODONTICS

S. Ed Owens, Jr., D.D.S., M.S.D. & Shannon E. Owens, D.D.S., M.S.
1130 S. Hwy 89 – P.O. Box 7401 – Jackson, WY 83002
SPECIALISTS IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS
CERTIFIED BY THE AMERICAN BOARD OF ORTHODONTICS

Today's Date:_____

Patient's Name:_____ D.O.B.:_____ Age:_____

Mailing Address:_____ City/State/Zip:_____

Primary Phone#:_____ Male:_____ Female:_____ Preferred Name:_____

School:_____ Grade:_____ Hobbies, Sports:_____

General Dentist:_____ Last Visit:_____Were teeth cleaned?:_____

Other Family Members Seen by Us:_____

Orthodontic consult prompted by: Dentist Parents Physician Friend Other_____

Does the patient have Orthodontic Insurance? Y N <u>If Yes, please present ID card to receptionist and answer the following</u>:

Name of the Policy Holder: _____ Birth Date: _____

Relationship to Patient:_____ SS#:_____

<u>FAMILY INFORMATION</u>

Father's Name:_____ Employer:_____

D.O.B.:_____ SS#:_____ Phone#:_____Home/Cell/Work

Mother's Name:_____ Employer:_____

D.O.B.:_____ SS#:_____ Phone#:_____Home/Cell/Work

Parent's Marital Status:_____ Child Living With:_____

Email address for Mom or Dad:_____

You will receive either a text or email appointment reminder the day before each appointment.
Please choose which you would prefer:

Text: Phone # _____

Email: Address _____

MEDICAL HISTORY

Has your child ever had the following?

Y N Heart Attack / Stroke
Y N Cancer / Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Arthritis
Y N Artificial Valves / Joints
Y N Sinus Problems
Y N Allergies (Seasonal)
Y N Allergies to Medications_____
Y N Metal Allergies_____
Y N Latex Allergies
Y N High / Low Blood Pressure
Y N Severe / Frequent Headaches
Y N Emotional Problems
Y N Epilepsy / Seizures
Y N Diabetes / Tuberculosis
Y N Blood Disorders
Y N Endocrine Problems
Y N Hepatitis
Y N Hearing Disorder
Y N Frequent Colds
Y N Frequent Stuffy Nose
Y N Frequent Sore Throat or Tonsillitis

Physician:_____

Has the patient reached Puberty? Y N

DENTAL HISTORY

Has your child ever had the following?

Y N Previous Orthodontic Consult
Date:_____
Y N Previous Orthodontic Treatment
Date:_____
Y N Pain / Discomfort in Jaw Joint
(TMJ / TMD)
Y N Injury to the Face or Jaw
Y N Injury to the Teeth_____
Y N Grinding of the Teeth
Y N Clenching of the Teeth
Y N Tongue Thrusting
Y N Mouth Breathing
Y N Nail Biting / Chewing Habits
Y N Thumb / Finger Sucking (Age_____)
Y N Sleep Apnea
Y N Snoring
Y N Difficulty with Extractions or
other Dental Treatments
Y N Numerous Cavities
Y N Speech Problems
Y N Pain or Clicking in the Jaw Joint
Y N Teeth injured due to accidents

Reason for today's visit:_____

_____

Present Medications:_____

_____

Has the patient received medical treatment from an allergist, or Ear, Nose & Throat specialist?

Y N If Yes, When?_____ By Whom?_____ Nasal Surgery? Y N

Tonsils Removed? Y N Adenoids Removed? Y N

Additional information you would like to share?: _____

Name & Signature of person completing this form: _____

Relationship to patient:_____ Date:_____