



CARROLL & SUTTON

O R T H O D O N T I C S

ORTHODONTIC CARE FOR CHILDREN AND ADULTS

Venice Office
4120 Woodmere Park Blvd., Suite 7
Venice, FL 34293
941-408-8542

Sarasota Office
1617 South Tuttle Ave., Suite 2B
Sarasota, FL 34239
941-366-1612

North Port Office
3045 Bobcat Village Center Rd
North Port, FL 34288
941-257-2000

Arcadia Office
7 N. Luther Ave.
Arcadia, FL 34266
863-494-1600

www.csorthodontics.com

Date: _____

Child's Full Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Birthdate: _____ Gender: _____

School Attending: _____

Name other children in the family and their ages: _____

How did you hear about our office? _____

Family Dentist: _____ City _____ State _____

Date of your child's last dental visit: _____

Has your child ever had an unfavorable experience in a dental office? _____

If so, describe: _____

Has your child ever received orthodontic treatment? _____ If so, by whom? _____

Reason for wanting an orthodontic consultation _____

Who is financially responsible for this account? Last name _____ First Name _____

Address (if different than patient) _____

Home Phone: _____ Cell Phone: _____

Name of person with whom patient resides if other than parent(s): _____

Relationship: _____

If you would like to access your appointment or account information via our website, please provide your email address: _____

Orthodontic Insurance Information

Insured's Name: _____ Date of Birth: _____ Insured's Soc Sec #: _____

Insurance Company: _____ ID #: _____ Group # _____

Ins. Co. Phone: _____ Insured's Employer: _____

Insurance Co. Address: _____

Do you have dual coverage? Yes No If yes:

Insured's name: _____ Date of Birth: _____ Insured's Soc Sec #: _____

Insurance Co.: _____ ID #: _____ Group # _____

Ins. Co. Phone #: _____ Insured's Employer: _____

Insurance Co. Address: _____

Patient's name: _____

HEALTH HISTORY

Yes No
_____ _____

Is your child in good health?

For the following questions, please mark yes (Y) or no (N). These answers are for our office's records only and are confidential. A thorough medical history is necessary for a proper orthodontic evaluation and treatment planning.

- | | |
|--|--|
| Y N Learning disabilities or need extra help with instructions? | Y N ADD or ADHD |
| Y N Birth defects or hereditary problems? | Y N Are you adopted? |
| Y N Tuberculosis, polio, mononucleosis, or pneumonia? | Y N Diabetes? |
| Y N Hepatitis, jaundice, or liver problem? | Y N Rheumatoid or arthritic conditions? |
| Y N Seizures, epilepsy, fainting spells, or neurological problems? | Y N Endocrine or thyroid problems? |
| Y N Mental health disturbance or depression? | Y N Cancer, tumor, radiation treatment? |
| Y N Vision, hearing, taste, or speech difficulties? | Y N Acid Reflux |
| Y N History of eating disorder, anorexia or bulimia? | Y N HIV or AIDS? |
| Y N Excessive bleeding or bruising tendency, anemia, or bleeding disorder? | Y N Problems of the immune system? |
| Y N Cardiovascular problems such as shortness of breath, angina, heart attack? | Y N High or low blood pressure? |
| Y N Heart murmur, rheumatic fever, inborn heart defects, artificial heart valves? | Y N Allergies or asthma? |
| Y N Ear, nose, throat, tonsil or adenoid conditions? | Y N Osteoporosis? |

Allergies or reactions to any of the following:

- Y N Aspirin or Ibuprofen?
Y N Penicillin or other antibiotics?
Y N Acrylic
Y N Metals (jewelry, clothing snaps, **nickel**)?
Y N **Latex** (gloves)?
Y N Local anesthetics (Lidocaine)
Y N Other substances: _____

Please list any medications, nutrient supplements, or non- prescription medicine that you are currently taking: _____

- Y N Please list any operations or hospitalizations: _____
Y N Being treated by another health care professional? For _____

For Girls Only:

- Y N Has child reached puberty? At what age? _____
Y N Is your child pregnant?

Dental History:

- | | |
|---|---|
| Y N Congenitally missing teeth or any permanent teeth removed? | Y N Extra or supernumerary teeth? |
| Y N Teeth sensitive to hot or cold; teeth throb or ache? | Y N Trauma or injury to permanent teeth? |
| Y N Any grinding, clenching, clicking or locking? | Y N Periodontal or gum problems? |
| Y N Thumb or finger sucking habit? Until what age? _____ | Y N Tongue thrusting? |
| Y N Ever been treated for TMD or TMJ problems? | Y N History of speech problems? |
| Y N Any pain in jaw or face, ringing in the ears, or severe headaches? | Y N Mouth breathing habit? |
| Y N Any relative with similar tooth or jaw treatment? | Y N Frequent canker sores or cold sores? |
| Y N Ever been or currently being treated for periodontal disease? | Y N Jaw fractures, cysts, or mouth infections? |

I have read and understand the above questions. I will not hold Carroll & Sutton Orthodontics, LLC responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform the practice.

Date Patient's Name Signed (Parent or Guardian)