ORTHODONTIC CENTRE IN MILTON

Dr. Lyndon Wong
D.D.S., CERT. ORTHO, FRCD(C)
Certified Specialist in Orthodontics

About your child (please complete in ink)

Name: _____ Preferred name: _____ Gender: M / F
Last First Middle

Date of Birth: _____ Age: _____ School: _____ Grade: _____
YY / MM / DD

Address: _____ Home Phone: _____
Street City Postal Code

Is your child adopted? ☐ Yes ☐ No Does your child know? ☐ Yes ☐ No

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

Parent/Guardian Information

Patient lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other: _____

Mother: _____ Address (if different): _____

Employer: _____ Daytime phone: _____ Cell phone: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Re-married

Email: _____ Dental Insurance: ☐ Yes ☐ No

Father: _____ Address (if different): _____

Employer: _____ Daytime phone: _____ Cell phone: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Re-married

Email: _____ Dental Insurance: ☐ Yes ☐ No

What is the reason for seeking an orthodontic evaluation? _____
Has an orthodontist been consulted previously? ☐Yes ☐No Reason: _____
Please list any other family members seen in our office and relationship: _____

Medical History

Name of Physician: _____

Address: _____

Yes	No	
☐	☐	Is your child currently being treated for any medical conditions? List: _____
☐	☐	Is your child currently taking any medications? List: _____
☐	☐	Does your child have any allergies? List: _____
☐	☐	Does your child have any allergies to medications? If yes, describe: _____
☐	☐	Has your child ever had any serious illnesses? If yes, describe: _____
☐	☐	Has your child ever been hospitalized or undergone any surgeries? _____
☐	☐	Has your child ever had prolonged bleeding after tooth extraction or injury?
☐	☐	If female, has your child begun menstruation?
☐	☐	Has your child had their adolescent growth spurt?

Does your child have, or ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Liver Disease	☐	☐	Nerve/Brain disease
☐	☐	Heart Murmur	☐	☐	Lung Disease	☐	☐	Seizures/Epilepsy
☐	☐	Heart/Valve disease	☐	☐	Asthma	☐	☐	Autism
☐	☐	Heart Attack/Stroke	☐	☐	Tuberculosis (TB)	☐	☐	Arthritis
☐	☐	Prosthetic Joint/Valve	☐	☐	Cancer/Radiation tx	☐	☐	Bone disorders
☐	☐	High/Low Blood Pressure	☐	☐	Diabetes	☐	☐	Vision/Hearing problems
☐	☐	Blood disorder	☐	☐	Stomach ulcers	☐	☐	Sleep Apnea
☐	☐	Hemophilia	☐	☐	Herpes (any type)	☐	☐	Sinus Problems
☐	☐	HIV/AIDS	☐	☐	Skin disease (ie Eczema)	☐	☐	Other: _____
			☐	☐	Migraine/headaches			

Please list any other significant information regarding your medical history:

_____

_____

_____

Dental History

What is your primary concern about your child's teeth and smile?_____
What is your child's primary concern about their teeth and smile? _____

Dentist: _____ Address: _____

Yes	No	
☐	☐	Is your child currently experiencing dental pain?
☐	☐	Has your child had previous orthodontics? When? _____ Which Dr? _____
☐	☐	Has your child ever injured their teeth or mouth? Describe: _____
☐	☐	Has your child complained about soreness/tightness/pain in their jaw muscles?
☐	☐	Has your child complained about clicking/popping/grinding in their jaw joints?
☐	☐	Has your child experienced difficulty opening or closing their jaw?
☐	☐	Has your child's jaws ever "locked"?
☐	☐	Does your child have any of the following habits? Finger / thumb sucking | Lip biting | Nail biting
☐	☐	Does your child breathe through their mouth or with their mouth open regularily?

How often does your child brush and floss each day? Brush _____ times per day Floss _____ times per day

Dental Insurance Information

Primary Insurance Company: _____
Address: _____ Group/Plan Number: _____
Policy holder name: _____
Secondary Insurance Company: _____
Address: _____ Group/Plan Number: _____
Policy holder name: _____

I acknowledge that I read and understand the above medical and dental information and certify the above information is correct. If there are any changes to the above information, I will notify the office of any changes that occur. I also give my permission for Dr. Wong and his team to perform an initial orthodontic evaluation.

_____	_____	_____	_____
Name	**Signature**	**Date**	**Dr. Lyndon Wong**