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# PATIENT INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Parent's Email \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Sex  M  F Home Phone \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Father's name \_\_\_\_\_ Birth date \_\_\_\_\_ Occupation \_\_\_\_\_

Employed by \_\_\_\_\_ How long \_\_\_\_\_ Work Phone \_\_\_\_\_

Dental Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Mother's name \_\_\_\_\_ Birth date \_\_\_\_\_ Occupation \_\_\_\_\_

Employed by \_\_\_\_\_ How long \_\_\_\_\_ Work Phone \_\_\_\_\_

Dental Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Whom may we thank for your referral? \_\_\_\_\_

CHIEF COMPLAINT (Reason for your consultation) \_\_\_\_\_

Does patient's problem resemble  Father  Mother  Adopted

Other children in family	Age	Sex	Had ortho treatment
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

School patient attends \_\_\_\_\_

Quality of school work  A  B  C  D  F  Honor Student  Special Program

Are you aware that the success of orthodontic treatment depends on cooperation  Yes  No

Will patient cooperation be  Excellent  Good  Fair  Poor  Indifferent

Musical instruments you play \_\_\_\_\_

Hobbies/Special interests \_\_\_\_\_

## MEDICAL HISTORY

Family physician \_\_\_\_\_ Last exam \_\_\_\_\_

Address \_\_\_\_\_

Is he/she currently under treatment  No  Yes \_\_\_\_\_

Is he/she currently taking medication  No  Yes \_\_\_\_\_

Has he/she ever been hospitalized  No  Yes \_\_\_\_\_

Is he/she allergic to medications/food/other  No  Yes \_\_\_\_\_

Has he/she tonsils/adenoids been removed  No  Yes (age) \_\_\_\_\_

Does patient have a history of:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Heart disorders   |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Endocrine disorders   | <input type="checkbox"/> Kidney disorders  |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Liver involvement |
| <input type="checkbox"/> Bone disorders     | <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Rheumatic fever   |

Comments \_\_\_\_\_

## DENTAL HISTORY

Family Dentist \_\_\_\_\_ Last exam \_\_\_\_\_

Do you have a history of:

- |   |  |
|---|--|
| <input type="checkbox"/> Nail biting                  | <input type="checkbox"/> Facial pain/discomfort _____  |
| <input type="checkbox"/> Frequent headaches           | <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Awake <input type="checkbox"/> Asleep    |
| <input type="checkbox"/> Clicking or popping jaws     | <input type="checkbox"/> Grinding or clenching <input type="checkbox"/> Day <input type="checkbox"/> Night |
| <input type="checkbox"/> Injuries to face/mouth/teeth |  |

Comments \_\_\_\_\_