TARDY ORTHODONTICS

Shelley R. Tardy, D.D.S., M.S.D.
Calvin J. Tardy, D.D.S., M.S.

1220 Highway 287 North, Mansfield, Texas 76063
817-453-8826 / 817-453-8830 (FAX)

PATIENT INFORMATION - AGE 17 & Under

Welcome to our office! The following is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for us to thoroughly diagnose any condition, we must have accurate background and health information on which to base our decisions. This information, which is important for our records and your health, is confidential. Thank you.

Date _____

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Preferred Name _____ Gender _____ DOB _____

School _____ Hobbies and Interests _____

Lives with (Check all that apply): Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent ☐ Other ☐

Responsible Party Name _____ (Last) _____ (First) _____ (Middle)

Relationship _____ DOB _____ SSN# _____

Email _____

Primary Phone _____ Mobile Yes ☐ No ☐ Belongs to _____

Secondary Phone _____ Mobile Yes ☐ No ☐ Belongs to _____

Does the patient live at multiple addresses? Yes ☐ % at primary ____ % at secondary ____ No ☐

Primary Home Address _____

City _____ State _____ Zip _____

Secondary Home Address _____

City _____ State _____ Zip _____

Name of Sibling or Step Sibling — First — Last

☐ ☐ _____ _____ DOB _____

☐ ☐ _____ _____ DOB _____

☐ ☐ _____ _____ DOB _____

☐ ☐ _____ _____ DOB _____

Is Patient Covered by Insurance for Orthodontic Treatment? Yes ☐ No ☐

If yes, provide the following:

Insurance Company _____ Insurance Phone # _____

Policy # _____ Group # _____

Is the Insurance provided through your employer? Yes ☐ No ☐ Employer _____

Is the responsible party listed above the policy holder? Yes ☐ No ☐

If No, provide the Policy Holder information below: Policy Holder Phone # _____

Policy Holder Name _____ (Last) _____ (First) _____ (Middle)

Relationship _____ DOB _____ SSN# _____

Does the Policy Holder live at one of the addresses listed above? Yes ☐ No ☐ Primary ☐ Secondary ☐

If No, Policy Holder Address _____

City _____ State _____ Zip _____

Comments: _____

Emergency Contact

Name _____ Phone _____ Relationship _____

Name (optional) _____ Phone _____ Relationship _____

ORTHODONTIC HISTORY

Has the patient had previous orthodontic consultation? Yes ☐ No ☐ Treatment? Yes ☐ No ☐

Date _____ Dr. _____

Orthodontic Consultation was prompted by: Patient ☐ Dentist ☐ Parent(s) ☐ Sibling ☐ Friend ☐ Other: _____

Patient's interest in treatment: Wants Treatment ☐ Treatment if necessary ☐ Unwilling but agrees ☐ Uncooperative ☐

Why did the patient seek this consultation? _____

What is the primary problem? _____

What is expected from orthodontic treatment? _____

MEDICAL HISTORY

Patient's Physician _____ City/State _____

Phone _____ Patient's Height _____ Patient's Weight _____ Adopted? Yes ☐ No ☐

Asthma	☐	Diabetes	☐	Heart Disease	☐	Hepatitis	☐
Anemia	☐	Epilepsy	☐	Hearing Disorder	☐	Rheumatic Fever	☐
Blood Disorder/Hemophilia	☐	Endocrine Problems	☐	Head or Face Injury	☐	Birth Defects	☐
Bone Disorders	☐	Emotional Problems	☐	Herpes	☐	Other (describe below)	☐

Comments: _____

_____

Has the patient been under the care of a physician during the past two years, other than for routine examination?

Yes ☐ No ☐ If yes, condition: _____

_____

Is the patient currently taking any drugs or medication? Yes ☐ No ☐

If yes, name(s): _____

Any allergies or reaction to any medication? _____

Has the patient reached puberty? Yes ☐ No ☐

RESPIRATORY HISTORY

Does the patient:

Have allergies to seasonal grasses? _____ Food(s) _____

Drugs _____ Other: _____

Snore while sleeping? Yes ☐ No ☐ Breathe through mouth? Seldom ☐ Sometimes ☐ Usually ☐

Have frequent colds? Yes ☐ No ☐ Have frequent "stuffy nose"? Yes ☐ No ☐

Have frequent sore throat or tonsillitis? Yes ☐ No ☐ Have chewing or swallowing difficulty? Yes ☐ No ☐

Received medical treatment from an allergist or ear, nose and throat specialist? Yes ☐ No ☐

If yes, what procedures were performed?

☐ Nasal Surgery Date _____ Provider _____

☐ Tonsils Removed Date _____ Provider _____

☐ Adenoids Removed Date _____ Provider _____

DENTAL HISTORY

Patient's Dentist _____ City/State _____ Phone _____

Does the patient have pain or clicking in jaw joints? Yes ☐ No ☐

Have any teeth been injured due to accidents or blows to the mouth? Yes ☐ No ☐

Has the patient had or been advised to have speech correction? Yes ☐ No ☐

Has the patient had (or does the patient now have) any of the following habits?

Thumb sucking _____ until age _____ Grinding of teeth _____ until age _____

Finger sucking _____ until age _____ Tongue thrusting _____ until age _____

Lip-biting or sucking _____ until age _____ Other habits _____

Has the patient had any unusual dental experiences? Yes ☐ No ☐ Specify: _____

_____

Date of last dental checkup _____ Were full-mouth or panoramic x-rays taken? _____

Patient Comments _____

_____

Whom may we thank for referring you to the office? _____

I believe the above information is accurate and agree to inform this office of any changes in my medical or dental history. I will promptly notify the office of any changes in insurance coverage. In addition, I authorize the doctor(s) at Tardy Orthodontics, P.C. to perform a complete orthodontic evaluation.

Signature _____ Date _____

Print Name _____

PRINT