CHILD

Tran Orthodontics

Dr. Paul E. Tran, DDS, MS

Name _____ (FIRST / M.I. / LAST) Prefers to be called _____

Address _____ (STREET / CITY / ZIP CODE)

Birth Date _____ Age _____ Sex _____ School _____

For Appointment Reminders: Email _____ Phone for Text/Voice _____

Who may we contact in case of emergency? _____ Phone _____

Brothers and Sisters:

Name _____ Birth Date _____ Name _____ Birth Date _____

Name _____ Birth Date _____ Name _____ Birth Date _____

Father's Name _____ (FIRST / M.I. / LAST) Father's Birth Date _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Home Address _____ (STREET / CITY / ZIP CODE)

Email _____ Home Tel. # _____ Cell Phone # _____

Employed By _____ Occupation _____

Does Father have Orthodontic Insurance? ❑ Yes ❑ No Name of Insurance Company _____

Insurance Tel # _____ Group # _____ SS# _____

Mother's Name _____ (FIRST / M.I. / LAST) Mother's Birth Date _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Home Address _____ (STREET / CITY / ZIP CODE)

Email _____ Home Tel. # _____ Cell Phone # _____

Employed By _____ Occupation _____

Does Mother have Orthodontic Insurance? ❑ Yes ❑ No Name of Insurance Company _____

Insurance Tel # _____ Group # _____ SS# _____

Person responsible for account _____

If divorce is involved, who is the Custodial Parent? _____

May patient information be released to the noncustodial parent? ❑ No ❑ Yes

If responsible party is other than the patient's parents, please give information ❑ Not Applicable

Name _____ Relationship to Patient _____

Address _____ Tel. # _____

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

In your opinion, what is your orthodontic problem? _____

302 Middletown Park Pl
Louisville, KY 40243

9531 US Highway 42
Prospect, KY 40059

502.245.8726
tranorthodontics.com

Health Questionnaire

TODAY'S DATE _____ PATIENT NAME _____ BIRTHDATE _____

FAMILY DENTIST _____ DATE OF LAST DENTAL VISIT _____ FAMILY PHYSICIAN _____

Have you ever had the following dental treatment?

- ❑ Orthodontics, date _____, by Dr. _____
- ❑ Periodontal treatment (gum treatment), date _____, by Dr. _____
- ❑ Mouthguard or splint therapy for jaw joint problems
- ❑ Jaw surgery to change your bite or to correct jaw joint

Do you have or have you had any of the following oral conditions?

- ❑ Sensitive teeth
- ❑ Clenching or grinding
- ❑ Bad breath
- ❑ Pain in the jaw, face
- ❑ Dry mouth
- ❑ Poorly functioning teeth
- ❑ Bleeding gums
- ❑ Pain around ear
- ❑ Mouth breathing
- ❑ Oral habits (thumb sucking, etc)
- ❑ Pain when opening mouth
- ❑ Discolored teeth
- ❑ Food wedging between teeth
- ❑ Swelling or lumps in the mouth
- ❑ Tobacco use
- ❑ Jaw joint sounds or pain
- ❑ Inability to floss between teeth
- ❑ Jaw gets stuck open or closed

Do you have or have you had any of the following medical conditions?

Yes	No		Yes	No		Yes	No	
❑	❑	Rheumatic fever	❑	❑	Congenital heart lesions/murmur	❑	❑	Heart condition
❑	❑	Diabetes	❑	❑	Anemia	❑	❑	Arthritis, swollen joints
❑	❑	Inflammatory rheumatism	❑	❑	Kidney problems	❑	❑	Tuberculosis
❑	❑	Asthma	❑	❑	Yellow jaundice	❑	❑	Hepatitis type _____
❑	❑	Liver disease	❑	❑	High blood pressure	❑	❑	Low blood pressure
❑	❑	Severe headaches	❑	❑	Dizziness or fainting	❑	❑	Convulsions or seizure
❑	❑	Eye problems	❑	❑	Ear problems	❑	❑	Sinus problems
❑	❑	Nose bleeds	❑	❑	Speech problems	❑	❑	Swallowing problems
❑	❑	Easy bruising	❑	❑	Venereal disease	❑	❑	HIV positive
❑	❑	ADD/ADHD						

Is this patient allergic to latex, metal or vinyl? _____ Yes No

Are you currently under a physician's care? If yes, describe _____ Yes No

Has patient ever been hospitalized or had any serious illness? If yes, describe _____ Yes No

Does the patient have any drug allergies? If yes, list medications _____ Yes No

Is the patient taking any medication? If yes, list medications _____ Yes No

Female patients - could patient possibly be pregnant at the present time? _____ Yes No

Has patient ever taken any medication for osteoporosis? _____ Yes No

Patient (or Parent) Signature _____ Date _____

Orthodontist's Signature: _____

Notes: _____

_____

_____

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