William L. Kochenour II DDS, MS, PA

Orthodontic Specialist for Children and Adults

727-796-2456

Child Patient Information Begin Here:

Name _____ _____ Sex: M or F Age:____ Birthdate _____
First MI Last Nickname

Address _____ City _____ ST____ ZIP_____

Adult Patient Information Begin Here:

Father, Self or Guardian Information

Name _____
First MI Last

Address _____

City _____ ST ____ Zip _____

Home #: _____ Work #:_____

Cell #: _____

Email: _____

DOB: _____ Age ___ Sex: ___ Marital Status:_____

SS#: _____DL#:_____

Mother or Spouse Information

Name _____
First MI Last

Address _____

City _____ ST ____ Zip _____

Home #: _____ Work #:_____

Cell #: _____

Email: _____

DOB: _____ Age ___ Sex: ___ Marital Status:_____

SS#: _____DL#:_____

Employer Information

Name _____

Address _____

City _____ ST ____ Zip _____

Employer Information

Name _____

Address _____

City _____ ST ____ Zip _____

Dental Insurance Company

Orthodontic Coverage? (Circle) Yes No

Name _____

Address _____

City _____ ST ____ Zip _____

Phone: _____

Group #: _____ Local or Union#:_____

Dental Insurance Company

Orthodontic Coverage? (Circle) Yes No

Name _____

Address _____

City _____ ST ____ Zip _____

Phone: _____

Group #: _____ ID#_____

Other Information

Dentist Name: _____

Physician Name: _____

School Name: _____

Musical Instruments Played: _____

Sports or Hobbies: _____

Other Children _____ D.O.B. _____

Other Children _____ D.O.B. _____

Whom may we thank for referring you? _____

Medical Information

Do you currently or have you ever had any of the following:

Heart Disease	Yes	No	Rheumatic/Yellow/Scarlet Fever	Yes	No	Heart Murmur	Yes	No
Respiratory Disease	Yes	No	Acquired Immune Deficiency Syndrome	Yes	No	Mononucleosis	Yes	No
Blood Disease	Yes	No	Rheumatism or Arthritis	Yes	No	Hepatitis	Yes	No
Liver Disease	Yes	No	Fainting or dizziness	Yes	No	Polio	Yes	No
Thyroid Disease	Yes	No	Measles/Mumps/Chicken Pox	Yes	No	Diabetes	Yes	No
Kidney Disease	Yes	No	Drug addiction	Yes	No	Anemia	Yes	No
H.I.V. Positive	Yes	No	Tubes in ear	Yes	No	Hemophilia	Yes	No
Venereal Disease	Yes	No	Stroke	Yes	No	Emphysema	Yes	No
Intestinal Disease	Yes	No	Artificial Joints/Valves	Yes	No	Epilepsy	Yes	No
Bone Disease	Yes	No	Fever blisters	Yes	No	Asthma or Hay Fever	Yes	No
Nervous/Emotional Problems	Yes	No	Facial stitches	Yes	No	Tuberculosis	Yes	No
High or Low Blood Pressure	Yes	No	Is Height & Weight normal for age	Yes	No	Broken bones	Yes	No
Endocrine Problems	Yes	No	Have you had a physical this year	Yes	No	Prolonged bleeding	Yes	No
Problems w/wounds healing	Yes	No	Have you reached puberty	Yes	No	Yellow Jaundice	Yes	No
Tumors or Cancer	Yes	No	Are you in good health	Yes	No	Radiation therapy	Yes	No
Sinus Problems	Yes	No	Do you smoke	Yes	No	Chemical therapy	Yes	No
Headache Problems	Yes	No	Are you under medical care	Yes	No	Blood transfusions	Yes	No
Birth Defects	Yes	No	Are you pregnant	Yes	No	Latex allergy	Yes	No

Are you taking any medications? Yes No
List of Medications: _____
_____

Are you allergic to anything? Yes No
What? _____
_____

Are you aware of any other disease, condition, or problem not listed above that we should know about? _____

If yes, what? _____

Dental History

Have you seen a General Dentist in the last year?	Yes	No
Any pain, clicking or discomfort in or near the ears?	Yes	No
Has your Mouth, Face or Teeth been injured by a fall or accident?	Yes	No
Have you been informed of missing or extra permanent teeth?	Yes	No
Are you aware of any "gum" problems?	Yes	No
Has a Physician or Dentist advised antibiotics before a Dental Exam?	Yes	No
Have your tonsils or adenoids been removed?	Yes	No
Do you feel you can benefit from Orthodontic Treatment?	Yes	No
Are you happy with your "Smile?"	Yes	No
Do you want to improve your "Smile" and "Bite?"	Yes	No
Are your teeth sensitive to heat, cold, sweets, or biting pressure?	Yes	No
Have you ever had your bite adjusted?	Yes	No
Have you been examined by an Orthodontist before?	Yes	No
If yes, when? _____		
Have other members of your family had Orthodontic treatment?	Yes	No
If yes, were they happy with the results?	Yes	No
If no, why?_____		

What age did your first baby tooth erupt? _____

Do you have or have you ever had any of the following habits:

Chew Gum	Yes	No
Cheek, Tongue or Lip Chewing	Yes	No
Thumb Sucking	Yes	No
Mouth Breathing	Yes	No
Finger Nail Biting	Yes	No
Clenching Teeth	Yes	No
Tongue Thrusting	Yes	No
Grind Teeth	Yes	No
Speech Problems	Yes	No
Do your jaw joints ever lock open or closed?	Yes	No
Have you ever been in an automobile accident?	Yes	No
Have you ever had any head or neck injuries?	Yes	No
Have you ever had cosmetic surgery?	Yes	No
Do any teeth feel loose?	Yes	No
Have you ever had a tooth removed?	Yes	No
Would you mind wearing braces?	Yes	No

In your own words, what is the Orthodontic problem? _____

What would you like Orthodontic treatment to accomplish? _____

I understand that where appropriate, credit bureau reports may be obtained:

_____

Patient Signature Date Parent Signature Date

Medical History Update

Has there been any change in your health since you last reviewed this form? (Circle) Yes No

If Yes, for what conditions? _____

Are you taking any new medications? If so, What? _____

Signature _____ Date _____