RHONDA H. CORMNEY, D.M.D., P.S.C.
SPECIALIST IN ORTHODONTICS

Name ______________________________ Date __________

Birthdate ____________ Age ______ School ______________________

Home Address ____

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Hobbies/Sports ____

Whom may we thank for referring you? ______________________________

General Dentist ______________________________ Last Cleaning? __________

Mother's Name ____________________ Social Security No.:______________

Employer ____

Home Phone____________ Cell Phone____________ Work Phone____________

Father's Name ____________________ Social Security No.:______________

Employer ____

Home Phone____________ Cell Phone____________ Work Phone____________

Billing Address ____

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Do you have Orthodontic Insurance? ______________________________

Insurance Co. Name ____

Address ____

Phone ____

Plan or Policy # ____

Insured's Name ____

Relationship to Patient ____

Insured's Birthday ________________ SS# ______________________

Insured's Employer ____

Has your child ever been evaluated or had orthodontic treatment before? ____________

What is your main reason for consulting an Orthodontist? ______________________

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Has there been any injuries to face, mouth or chin? ___________________________

Have adenoids or tonsils been removed? ___________________________________

Does your child have any extra or missing teeth? ___________________________

Has your child ever had any pain in the jaw joint? ___________________________

Does your child brush and floss daily? _____________________________________

Child's Physician ___________________________________Phone ____________

Allergies to any drugs? ____

Medications presently taking? ____

Has your child ever had any of the following medical problems?

Y N Heart Murmur

Y N Rheumatic Fever

Y N HIV+/AIDS

Y N Hemophilia

Y N Hepatitis

Y N Diabetes

Y N Congenital Heart Defect

Y N Convulsions/Epilepsy

Y N Hearing Impairment

Y N Allergic to Latex/Metals

Please discuss any medical problems your child has had. ________________________

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Does your child have any of the following habits?

Y N Thumb/Finger Sucking

Y N Lip Sucking/Biting

Y N Clenching/Grinding Teeth

Y N Nursing Bottle Habits

Y N Mouth Breather

Y N Speech Problems

Y N Nail Biting

Y N Tongue thrust

* I understand that the information that I have given is correct to the best of my knowledge, That it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

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Signature Date