WELCOME

To Dr. Richard U. Mattson's
Orthodontic Office

TELL US ABOUT YOUR CHILD

Today's Date_____ Male____ Female____

Child's Name_____

Child's Birth Date: _____/_____/_____ Age:_____

School_____ Grade_____

Hobbies/Sports:_____

Child's Home Address:

_____

_____

Phone Number:_____

List brothers/sisters _____

_____

Have they been treated in our office? ____yes ____no

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: _____Single _____Widowed
_____ Married _____ Divorced

WHAT ARE YOUR MAIN CONCERNS?

_____

_____

_____

Has your child been seen by another Orthodontist?
Yes _____ No _____

Have there been any injuries to the face/jaw/mouth /teeth?
Yes _____ No _____

List any musical instruments played _____

Does your child brush daily? Yes _____ No_____
Does your child floss daily? Yes _____ No _____

PATIENT MEDICAL HISTORY

Y N Tuberculosis
Y N Asthma
Y N Diabetes
Y N Hepatitis
Y N HIV+ or AIDS
Y N Rheumatic Fever
Y N Abnormal Bleeding
Y N Epilepsy (Diantin)
Y N Tonsils Removed
Y N Adenoids Removed
Y N Latex Allergy
Y N Allergy to any Drugs
Y N Heart Problems
Y N Emotional Problems
Y N Cancer
Y N Dialysis/Transplant/Transfusion/Hospitalization
Please List:_____
_____

Is your child currently under the care of a physician?
Yes _____ No _____

Please list any medication your child is currently taking.

_____

_____

Please list all medications your child is allergic to.

_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y N Clenching/Grinding Teeth

Y N Lip Sucking/Biting

Y N Mouth Breather

Y N Nail Biting

Y N Speech Problems

Y N Thumb/Finger Sucking

Y N Tongue Thrust