

# ◇ Donald J. Turner, D.D.S. ◇

Orthodontics, T.M.J.  
Facial Orthopedics

2424 Enterprise Road  
Suite B  
Clearwater, FL 33763  
Phone: (727) 797-5460

## Welcome To Our Office

To better understand your dental health needs and your feelings toward orthodontics, we'd like you to help us become better acquainted. If you are registering in our office please tell us when you have completed the questions. Thank you!

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Last First MI Nickname Month Day Year

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Street Apt # City ZIP

School \_\_\_\_\_ Grade \_\_\_\_\_ Child's Dentist \_\_\_\_\_ Child's Physician \_\_\_\_\_

Brothers: Age \_\_\_\_\_ Sisters: Age \_\_\_\_\_ (Circle age of children that have had or are having ortho. treatment)

Whom may we thank for referring you? \_\_\_\_\_  
(Dentists, relatives, friends who helped you decide to choose us.)

### Father

### Mother

Name [Dr. Mr.] \_\_\_\_\_ Name [Dr. Mrs.] \_\_\_\_\_

Address (if different from your child) \_\_\_\_\_  
Street City State ZIP Street City State ZIP

Employed By: \_\_\_\_\_  
(Business name or occupation) (Business name or occupation)

Business Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Person responsible for account \_\_\_\_\_  
Name Street City State ZIP

Whom shall we contact if unable to reach mother or father? \_\_\_\_\_ Preferred Appointments \_\_\_\_\_  
Name Phone Day(s) Time(s)

## MEDICAL/DENTAL HISTORY

Has your child been treated by a physician for:

Has your child ever had:

<table border="0" style="width: 100%;"> <tr> <td style="width: 80%;"></td> <td style="text-align: center; width: 10%;"><b>Yes</b></td> <td style="text-align: center; width: 10%;"><b>No</b></td> </tr> <tr> <td>Asthma .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Allergies .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Rheumatic fever .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Diabetes .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Epilepsy .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hyperactivity .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hepatitis .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Heart disorders .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Kidney problems .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Endocrine disorders .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Bone disorders .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Prolonged bleeding .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Removal of tonsils and/or adenoids .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Acquired Immune Deficiency .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>List: _____</p> <p>Has your child had a blood transfusion in the past three years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Allergic to: <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin  <input type="checkbox"/> Local anesthetic <input type="checkbox"/> Codeine  <input type="checkbox"/> Other: _____</p>		<b>Yes</b>	<b>No</b>	Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems .....	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	Bone disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>	Removal of tonsils and/or adenoids .....	<input type="checkbox"/>	<input type="checkbox"/>	Acquired Immune Deficiency .....	<input type="checkbox"/>	<input type="checkbox"/>	Other .....	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0" style="width: 100%;"> <tr> <td style="width: 80%;"></td> <td style="text-align: center; width: 10%;"><b>Yes</b></td> <td style="text-align: center; width: 10%;"><b>No</b></td> </tr> <tr> <td>An injury to face/teeth .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Finger sucking habit .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Tooth grinding habit .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Speech or gag problem .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Jaw opening click or pain .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Mouth breathing .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Cleft lip/palate surgery .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Routine high use of sweets ...</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Primary (baby) teeth removed</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Permanent teeth removed .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>A previous orthodontic exam ...</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>When: _____</td> <td></td> <td></td> </tr> <tr> <td>Whom: _____</td> <td></td> <td></td> </tr> <tr> <td>Other dental concerns .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p style="text-align: center;">Taking medicines <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>List: _____</p> <p>Hospitalized .....</p> <p>For what? 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Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**PLEASE CONTINUE ON NEXT PAGE**

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Do you have orthodontic insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ Company Name \_\_\_\_\_

Group Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**FURTHER INSIGHTS**

How may we help you? Please tell us what you feel is your child's orthodontic problem. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How does your child feel about his/her teeth and facial appearance? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is your child's reaction to orthodontic treatment and "braces"? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Has your child had any unfavorable dental experiences? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please tell us about your child's interests and activities. (Sports, hobbies, music, church and school activities, or collections)

\_\_\_\_\_  
\_\_\_\_\_

Does your child accept responsibility? (Making up room, caring for teeth, completing school assignments on time, caring for pet, helping with home chores, after school job, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please describe your child's individual character or nature (Dependable, quiet, outgoing, self-conscious, leader, sensitive, one-of-the-group, motivated, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What has been helpful in maintaining your child's interest and in helping him/her learn new concepts? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If you have any additional concerns, questions, or expectations you wish to be aware of or you wish us to answer, please describe:

\_\_\_\_\_  
\_\_\_\_\_

**Thank You!**