

# Reading Orthodontics

**Leo Spyrou, D.M.D.**

2 Haven Street, Suite 202 Reading, MA 01867

Ph: 781-944-7970 Fax: 781-942-7259

www.readingortho.com

## Personal History Form - Child

Name \_\_\_\_\_ Nick Name \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Age \_\_\_Y \_\_\_M  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Email \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
 Physician \_\_\_\_\_ Dentist \_\_\_\_\_ Referred by \_\_\_\_\_  
 Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employed by \_\_\_\_\_  
 Business Address \_\_\_\_\_ Phone \_\_\_\_\_ EXT \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employed by \_\_\_\_\_  
 Business Address \_\_\_\_\_ Phone \_\_\_\_\_ EXT \_\_\_\_\_  
 Name & Ages of Siblings \_\_\_\_\_ Are Parents Divorced? \_\_\_ Separated? \_\_\_ Widowed? \_\_\_  
 Person Financially Responsible \_\_\_\_\_ Relationship \_\_\_\_\_  
 Dental Insurance: YES NO Orthodontic Coverage: YES NO  
 Plan Name \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_  
 Subscriber's ID \_\_\_\_\_ Subscriber's D.O.B. \_\_\_/\_\_\_/\_\_\_

## Medical History (Please circle yes or no and fill in blanks where required)

1. Date of last medical exam \_\_\_\_\_ Is patient in good health? YES NO
2. Have patients tonsils and/or adenoids been removed? At what age? \_\_\_\_\_ YES NO
3. Has patient reached puberty? YES NO
4. Are height and weight normal for age? YES NO
5. Frequent colds, sore throat, or ear infections? YES NO
6. Any history of major illness? If yes please list \_\_\_\_\_ YES NO
7. Any allergy or drug sensitivity? If yes please list \_\_\_\_\_ YES NO
8. Taking any medication now/ If yes please list \_\_\_\_\_ YES NO
9. Is the patient under medical? or psychological care now? Explain \_\_\_\_\_ YES NO
10. Circle any of the following for which the patient has been or is being treated:
 

Diabetes	Hepatitis	Pos. HIV Antibody	Heart Trouble	Drug Addiction
Arthritis	Cancer	Nervous Disorders	Brain injury	Blood Transfusion
Asthma	Herpes	Endocrine Problems	Tuberculosis	Rheumatic Fever
AIDS	Epilepsy	Thyroid Problems	Infectious Mono	Prolonged Bleeding
Tonsillitis	ARC	High Blood Pressure	Pregnancy	Low Blood Pressure
11. Does the patient have, or ever had any medical condition not mentioned above? YES NO

## Dental History

1. Date of last dental exam \_\_\_\_\_ Full mouth X-rays taken? When? \_\_\_\_\_ YES NO
2. Have there been any injuries to the face, mouth or teeth? Describe \_\_\_\_\_ YES NO
3. Has the patient ever sucked thumb or fingers? Until what age? \_\_\_\_\_ YES NO
4. Any oral habits such as lip biting, tongue thrusting, finger sucking, or nail biting? YES NO
5. Has the patient ever had speech problems or speech therapy? YES NO
6. Is the patient a mouth breather while asleep or awake? YES NO
7. Has the patient ever had pain, clicking or popping of the jaw joints? Any TMJ Problems? YES NO
8. Has the patient seen an Orthodontist? If so Dr.'s name \_\_\_\_\_ Records taken? YES NO
9. Have either parent or other children had orthodontic treatment? YES NO
10. Would you consider the patient's diet high in sweets? YES NO
11. Patient's attitude toward braces: Complacency \_\_\_\_\_ Eagerness \_\_\_\_\_ Resignation \_\_\_\_\_ Antagonism \_\_\_\_\_
12. List any musical instrument played \_\_\_\_\_ Hours per day \_\_\_\_\_ Hobbies \_\_\_\_\_
13. What orthodontic problems are you most concerned about? \_\_\_\_\_
14. What problem is your dentist most concerned about? \_\_\_\_\_

Person filling out this form please sign: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**CONSENT FOR USE AND  
DISCLOSURE OF HEALTH INFORMATION**

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(PATIENT NAME)

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations for the patient named on this consent

We reserve the right to change our privacy practices as described in our **Notice of Privacy Practices**. If we change our privacy practices, we will issue a revised document. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting our office.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took before we received your written notice. We may decline to treat or continue treating you if revoke this Consent.

I have had full opportunity to read and consider the contents of this **Consent Form** and **Notice of Privacy Practices**. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations for the patient named on this form.

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SIGNED (PATIENT OR PARENT IF MINOR)

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DATE

**You are entitled to a copy of this Consent form after you sign it**