Robert W. Motherwell, DDS, MSD

Orthodontic Specialist for Children and Adults
5700 Colleyville Blvd.
Colleyville, TX 76034

ADOLESCENT PATIENT INFORMATION

PATIENT INFORMATION

Date ____________________

Patient's Name ____ Nickname ____________________

Address ____

Home Phone ____________________ Birth Date _____/_____/_____ Age________ Sex __________

School ____ Grade ______________

Parent's EMAIL ______________________________ Parent's Cell Phone ____________________

Whom may we thank for referring you to our office? ______________________________

General Dentist ____ City ____________________

Family Physician ____ City ____________________

Siblings: Name ____________________ Age ______ Name ____________________ Age _______

RESPONSIBLE PARTY INFORMATION

Father's Name ____

Address ____

Home Phone ____________________ Work Phone ______________________________

EMAIL Address ____

Employer ____________________ Occupation ____________________ Years Employed _________

Mother's Name ____

Address ____

Home Phone ____________________ Work Phone ______________________________

EMAIL Address ____

Employer ____________________ Occupation ____________________ Years Employed _________

Person Financially responsible for this account Father ☐ Mother ☐

Marital status single ☐ married ☐ divorced ☐ widowed ☐

DENTAL INSURANCE INFORMATION

Insured's Name ____________________ Birth Date ____/____/____ ID# ____________________

Insurance Company ______________ Group No. ____________________ Local No. ______________

Insurance Co Address ____ Phone ____________________

Do you have dual coverage? ☐ Yes ☐ No

2nd Insured's Name ____________________ Birth Date ____/____/____ ID# ____________________

Insurance Company ______________ Group No. ____________________ Local No. ______________

Insurance Co Address ____ Phone ____________________

Do you have dual coverage? ☐ Yes ☐ No

PATIENT INFORMATION

Is Patient in Good health? ______ ❑ Yes ❑ No

Does patient have a history of major illness ? ______ ❑ Yes ❑ No

Has patient been under the care of a physician for a major illness? ______ ❑ Yes ❑ No

ASTHMA	❑ Yes ❑ No	CANCER	❑ Yes ❑ No	HIGH BLOOD PRESSURE	❑ Yes ❑ No
DIABETES	❑ Yes ❑ No	ANEMIA	❑ Yes ❑ No	PROLONGED BLEEDING	❑ Yes ❑ No
PNEUMONIA	❑ Yes ❑ No	EPILEPSY	❑ Yes ❑ No	FAINTING OR DIZZINESS	❑ Yes ❑ No
HEART TROUBLE	❑ Yes ❑ No	NERVOUS DISORDER	❑ Yes ❑ No	LIVER INVOLVEMENT	❑ Yes ❑ No
RHEUMATIC FEVER	❑ Yes ❑ No	TUBERCULOSIS	❑ Yes ❑ No	KIDNEY INVOLVEMENT	❑ Yes ❑ No
BONE DISORDERS	❑ Yes ❑ No	TMD SYMPTOMS	❑ Yes ❑ No	ENDOCRINE PROBLEMS	❑ Yes ❑ No
HEPATITIS	❑ Yes ❑ No	AIDS/HIV	❑ Yes ❑ No		

Have tonsils and adenoids been removed? What age? ______ ❑ Yes ❑ No

List any drug or medications now being taken. Give reason:

______

List any drug allergies or drug sensitivities: ______

Other allergies or sensitivities (e.g. latex, metals) ______

DENTAL HISTORY

Have there been injuries to the face, mouth, or teeth? ______ ❑ Yes ❑ No

Has the patient ever sucked a thumb or finger? Until what age? ______ ❑ Yes ❑ No

Does the patient have any speech problems? ______ ❑ Yes ❑ No

Have you been informed of any missing or extra permanent teeth? ______ ❑ Yes ❑ No

Has an orthodontist been consulted previously? ______ ❑ Yes ❑ No

Has either parent or patient had orthodontic treatment? ______ ❑ Yes ❑ No

In your own words, what is the orthodontic problem:

______

What would you like orthodontic treatment to accomplish?

______

______	______	______
Patient Signature	Date	Parent Signature

______

Doctor Signature

Doctor's Notes: