Dr. Traci R. Fernandes – Specialists in Orthodontics

Patient prefers to be called	Patient prefers to be called		x
Home Address	Home Address Same or list if different Final Address Same or list if different Final Address Same or list if different Final Address Same or list if different Parcer's Marital Status Single Married Separated Divorced Remarried Waldowed Mother Cleardina's Name Bitth Date SS # Address State State State State State Address State State State State State State State State State Address State	Patient full/legal name Sex Patient prefers to be called Phone # Bir	
Mailing Address Same or list if different Email Address Mother Futher Other	Mailing Address Same of list of different Conde Patient lives with: South Parents Mother Collective Conde Patient lives with: South Parents Mother Collective Col		
Name of School	Name of School Grade Patient lives with: Both Parcis Mortier Gother		
Whom may we thank for referring you? Names of other family members being treated in our office Please list any sports, hobbies or interests For the following questions mark "Y" for Yes and "N" for No. The answers are for office record only and are confidential. A thorough and complete history is vital to a proper orthodontic evaluation. Has the patient ever been diagnosed with: Hepatitis	Whom may we thank for referring you? Names of other family members being treated in our office	Name of School Grade Patient lives with: Both Parents	Mother Father Other
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Arthritis	Anemia	Hepatitis	
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Herpes	Herpes		
Cancer Y N Diabetes Y N Liver Involvement Y N Is the patient in good health? Has the patient seen a physician in the last 2 years? Y N If yes, please explain	Cancer Y N Diabetes Y N If no, please explain		
Has the patient seen a physician in the last 2 years?	Has the patient seen a physician in the last 2 years?		ment TY N
Has the patient had adenoids or tonsils removed?	Has the patient had adenoids or tonsils removed?		
Has the patient had adenoids or tonsils removed?	Has the patient had adenoids or tonsils removed?	Has the patient seen a physician in the last 2 years? Y N If yes, please explain	
Has the patient had adenoids or tonsils removed?	Has the patient had adenoids or tonsils removed?	History of major illness/congenital disorder?	
Has the patient had adenoids or tonsils removed?	Has the patient had adenoids or tonsils removed?	Does patient have any behavioral/psychiatric disorders?	
Has the patient had adenoids or tonsils removed?	Has the patient had adenoids or tonsils removed?	Any drugs or medications now being taken?	
Has the patient had adenoids or tonsils removed?	Has the patient had adenoids or tonsils removed?	Any allergies to medications, anesthetics, latex, acrylic,	
Has the patient ever used Phen-fen?	Has the patient ever used Phen-fen?	metals or other materials?	
(For females) Is the patient pregnant?	Comparison City C		
Has the patient begun puberty?	Has the patient begun puberty?		
Is the patient currently or previously taken	Is the patient currently or previously taken		
Name of Physician City Phone # Has the patient ever sucked a thumb/finger? Does the patient clench or grind their teeth? Does the patient have speech problems? Is the patient apprehensive toward dental visits? Has the patient had previous orthodontic examinations? Has the patient had previous orthodontic examinations? Have there ever been injuries to the face, mouth or teeth? City Phone # If yes, until what age Y N If yes, please explain If yes, please explain Was treatment provided? N N If yes, please explain Y N If yes, when Was treatment provided? Y N N If yes, please explain	Name of Physician City		
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Is the patient apprehensive toward dental visits?	Is the patient apprehensive toward dental visits?		
Has the patient had previous orthodontic examinations? \[\begin{array}{cccccccccccccccccccccccccccccccccccc	Has the patient had previous orthodontic examinations?		
Have there ever been injuries to the face, mouth or teeth?	Have there ever been injuries to the face, mouth or teeth?		
	Does the patient predominantly breathe through their nose?		
Has the parient or other children had orthodontic treatment?	Date of last dental examination Were X-rays taken?		
Has the parent or other children had orthodontic treatment?	Date of last dental examination Were X-rays taken?	Has the patient been informed of missing or extra permanent teeth?	
	Date of last dental examination Were X-rays taken?	Has the parent or other children had orthodontic treatment?	
Has the patient had any clicking/discomfort in the jaw joints near the ears?	Date of last dental examination Were X-rays taken?	Has the patient had any clicking/discomfort in the jaw joints near the ears?	
What is your or dentist's orthodontic concern?	Date of last dental examination Were X-rays taken?	What is your or dentist's orthodontic concern?	
Name of Dentist City Phone #	Name of Dentist City Phone #	Ivalue of Dentist City Phone #	