

JAMES W. KOGLIN, D.D.S., LLC
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Date _____

Practice Limited to Orthodontics

ORTHODONTIC MEDICAL and DENTAL CASE ANALYSIS QUESTIONNAIRE

Name: _____ Prefers to be called _____ Sex _____ Birth Date _____ Age _____
(last name) (m) (first name) Home: _____

Address _____ Telephone Daytime: _____

Father's NAME (Dr., Mr.) _____

Address _____

Mother's NAME (Miss, Dr., Mrs., MS.) _____

Address _____

Financially Responsible Party (NAME & ADDRESS) _____

Orthodontic Insurance _____

Patient's Brothers: Ages () () () () Patient's Sisters: Ages () () () ()

Dentist _____ City _____ Pediatrician or Physician _____ City _____

Present Weight _____ Present Height _____

Are tonsils and adenoids present? _____ Yes or No

Were the primary or baby teeth slow in erupting? _____ Yes or No

Were any primary or baby teeth removed by their dentist? _____ Yes or No

Has your child had any major falls, accidents, or operations? _____ Yes or No

Is he/she presently being treated by a physician? _____ Yes or No

Have they been in the hospital during the last two years? _____ Yes or No

If so, for what _____

Any difficulty in breathing through their nose? _____ Yes or No

Any difficulty in swallowing or chewing food? _____ Yes or No

Any clicking or pain when they open or close their mouth? _____ Yes or No

Does your child have or had any of the following: Please underline or circle all that apply.

- | | | | | |
|-----------------|------------|-----------------------|-----------------------------|---------------|
| Rheumatic fever | Chickenpox | Repeated headaches | Drug allergy | Heart disease |
| Convulsions | Measles | Repeated sore throats | (penicillin, aspirin, etc.) | Hemophilia |
| Diabetes | Mumps | Repeated colds | Broken bones | Hepatitis |
| Tuberculosis | Pneumonia | Asthma | Blood diseases | HIV Positive |
| Polio | Anemia | Hay fever | Heart murmur | Food allergy |

Does your child have any of the following habits? Please underline or circle.

- | | | |
|-----------------|---------------------------|-------------|
| Thumbsucking | Tooth grinding (at night) | Nail Biting |
| Fingersucking | Lip Biting | |
| Tooth clenching | Pencil biting | |

School (or employment) _____ Grade _____ How are your child's grades? _____

Music lessons _____ Hobbies _____ Sports _____

Would your child mind wearing braces if they thought it would do some good? Yes _____ No _____

How did you hear about us? _____