# PERSONAL INFORMATION

DILLEHAY ORTHODONTICS
10311 E. Stonegate Ln. • Wichita, KS 67206
9909 W. 21st St. N. • Wichita, KS 67205
1821 E. Madison Ave., Ste. 1300 • Derby, KS 67037
316.683.6518 • 800.794.1818 • Fax 316.683.0918 • toothmovers.org

DIPLOMATE OF THE AMERICAN BOARD OF ORTHODONTICS

J. KENDALL DILLEHAY, DDS, MS
J.K. DILLEHAY, DDS, MS

Patient's Name: _____ Sex _____
Last First Nickname

Home Address _____ Phone _____

Date _____ Age _____ Birthdate _____ School _____

1. Responsible Party _____ Relationship _____
   Address (If different) _____ Phone _____
   Business of Responsible Party _____ Bus. Phone _____
   Insurance Co. _____ SS# _____
   Policy # _____ Birthdate _____
   E-mail _____
2. Responsible party _____ Relationship _____
   Address (If different) _____ Phone _____
   Business of Responsible Party _____ Bus. Phone _____
   Insurance Co. _____ SS# _____
   Policy # _____ Birthdate _____

Other Family Members who have been seen by our Doctors: _____
How did you first hear of our office? _____
General Dentist _____
Patient's favorite hobbies and special interests: _____

The American Association of Orthodontists recommends that a child's first visit to an orthodontist should take place when an orthodontic problem is first detected. Depending on the nature of the problem, whether it's jaw growth problems, tooth problems or both, this first visit could take place as early as age 2 or 3, as the primary teeth erupt. Whether or not an orthodontic problem is detected, however, a child should visit an orthodontist for an evaluation no later than age 7. This may surprise you because orthodontic treatment is usually associated with adolescence. Though treatment does not necessarily begin at this early age, an examination is very important to ensure maximum dental health for your child.

If you would like for us to place the names of your younger children in our file for future examination, please list their names and dates of birth below. We will send you a reminder card shortly after their seventh birthday.

| NAME | DATE OF BIRTH |
|---|---|
| | |
| | |
| | |
| | |
| | |

Date _____

Child's Name _____

Birthdate _____

Height_____ Weight_____

What is your relationship to this child? _____

DILLEHAY ORTHODONTICS

## Child Medical History

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Is your child in good health? Yes No

Has there been any change in your child's general health within the past year? Yes No

When was your child's last physical examination?_____

Is your child now under the care of a physician? Yes No

If so, what condition is your child being treated for? _____

Your child's physician name and address _____

_____

Address City/State Zip

Has your child ever had any *serious* illness or operation? Yes No

If so, what was the illness/operation? _____

Has your child ever had joint replacement surgery? Yes No

Has your child ever been hospitalized or had a serious illness in the past 5 years? Yes No

If so, what was the problem?_____

Does your child have/has your child had any of the following diseases/conditions:

- Rheumatic fever/rheumatic heart disease? Yes No
- Congenital heart lesions? Yes No
- Cardiovascular diseases? Yes No
  - Pain in the chest upon exertion? Yes No
  - Shortness of breath after mild exercise? Yes No
  - Shortness of breath when lying down/ require extra pillows when he/she sleeps? Yes No
  - Does your child have a cardiac pacemaker? Yes No
  - Had any heart valves replaced? Yes No
  - Had heart bypass surgery? Yes No
- Allergies? Yes No
- Sinus trouble? Yes No
- Asthma/hay fever? Yes No
- Hives/skin rash? Yes No
- Fainting spells/seizures? Yes No
- Diabetes? Yes No
  - Urinate (pass water) more than 6 times a day? Yes No
  - Thirsty much of the time? Yes No
  - Frequent drymouth? Yes No
- Hepatitis, jaundice or liver disease? Yes No
- Stomach ulcers? Yes No
- Kidney trouble? Yes No
- Tuberculosis? Yes No
- Does your child have a persistent cough/cough up blood? Yes No
- Low blood pressure? Yes No
- Venereal disease? Yes No
- Other _____

Has your child ever had abnormal bleeding associated with previous extraction, surgery, or trauma? Yes No

- Does your child bruise easily? Yes No
- Has your child ever required a blood transfusion? Yes No
- If so, please explain _____

Does your child have any blood disorder such as anemia? Yes No

Has your child had surgery /x ray treatment for a tumor, growth or other condition of his/her head/neck? Yes No

Is your child taking any drugs/medication? Yes No

- If so, please list _____

Is your child taking any of the following:

- Antibiotics/sulfa drugs? Yes No
- Anticoagulants (blood thinners)? Yes No
- Medicine for high blood pressure? Yes No
- Cortisone (steroids)? Yes No
- Tranquilizers? Yes No
- Antihistamines? Yes No
- Aspirin? Yes No
- Insulin, tolbutamide (Orinase) or similar drug? Yes No
- Digitalis/drugs for heart trouble? Yes No
- Nitroglycerin? Yes No
- Oral contraceptive/other hormonal therapy? Yes No
- Other _____

Is your child allergic to/has your child ever reacted adversely to:

- Local anesthetics? Yes No
- Penicillin/other antibiotics? Yes No
- Sulfa drugs? Yes No
- Barbiturates, sedatives or sleeping pills? Yes No
- Aspirin? Yes No
- Iodine? Yes No
- Codeine/other narcotics? Yes No
- Other _____

Has your child had any serious trouble associated with any previous dental treatment? Yes No

- If so, please explain _____

Does your child have any disease, condition or problem not listed above that you think we should know about? Yes No

If so, please explain _____

Is your child employed in any situation which exposes him/her regularly to x rays or other ionizing radiation? Yes No

Is your child wearing contact lenses? Yes No

**Females:**

Is your child pregnant? Yes No

Does your child have any problem associated with her menstrual period? Yes No

Chief Dental Complaint:

_____

Signature of parent/guardian

DILLEHAY ORTHODONTICS

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DIPLOMATE OF THE AMERICAN BOARD OF ORTHODONTICS

J. KENDALL DILLEHAY, DDS, MS
J.K. DILLEHAY, DDS, MS

Patient's Name: _____ Sex _____
Last First Nickname

Home Address _____ Phone _____
Street City State Zip

Date _____ Age _____ Birthdate _____ School _____

1. Responsible Party _____ Relationship _____
   Address (If different) _____ Phone _____
   Business of Responsible Party _____ Bus. Phone _____
   Insurance Co. _____ SS# _____
   Policy # _____ Birthdate _____
   E-mail _____
2. Responsible party _____ Relationship _____
   Address (If different) _____ Phone _____
   Business of Responsible Party _____ Bus. Phone _____
   Insurance Co. _____ SS# _____
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Other Family Members who have been seen by our Doctors: _____

How did you first hear of our office? _____

General Dentist _____

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| NAME | DATE OF BIRTH |
|---|---|
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| | |
| | |
| | |

Date _____

Name _____

Birthdate _____

Social Security # _____

Height _____ Weight _____ Occupation _____

DILLEHAY ORTHODONTICS

## Adult Medical History

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health? Yes No

Has there been any change in your general health within the past year? Yes No

When was your last physical examination? _____

Are you now under the care of a physician? Yes No

If so, what condition are you being treated for? _____

Your physician's name and address _____

Address City/State Zip

Have you ever had any *serious* illness or operation? Yes No

If so, what was the illness/operation? _____

Have you ever had joint replacement surgery? Yes No

Have you ever been hospitalized or had a serious illness in the past 5 years? Yes No

If so, what was the problem? _____

Do you have or have you had any of the following diseases/conditions:

- Rheumatic fever/rheumatic heart disease? Yes No
- Congenital heart lesions? Yes No
- Cardiovascular diseases (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)? Yes No
  - Pain in the chest upon exertion? Yes No
  - Shortness of breath after mild exercise? Yes No
  - Swelling of the ankles? Yes No
  - Shortness of breath when lying down/ require extra pillows when you sleep? Yes No
  - Do you have a cardiac pacemaker? Yes No
  - Heart valves replaced? Yes No
  - Heart bypass surgery? Yes No
- Allergies? Yes No
- Sinus trouble? Yes No
- Asthma/hay fever? Yes No
- Hives/skin rash? Yes No
- Fainting spells/seizures? Yes No
- Diabetes? Yes No
  - Urinate (pass water) more than 6 times a day? Yes No
  - Thirsty much of the time? Yes No
  - Frequent drymouth? Yes No
- Hepatitis, jaundice or liver disease? Yes No
- Arthritis? Yes No
- Inflammatory rheumatism (painful swollen joints)? Yes No
- Stomach ulcers? Yes No
- Kidney trouble? Yes No
- Tuberculosis? Yes No
- Do you have a persistent cough/cough up blood? Yes No
- Low blood pressure? Yes No
- Venereal disease? Yes No

Other _____

Have you ever had abnormal bleeding associated with previous extraction, surgery, or trauma? Yes No

- Do you bruise easily? Yes No
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If so, please explain _____

Do you have any blood disorder such as anemia? Yes No

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If so, please list _____

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- Antihistamines? Yes No
- Aspirin? Yes No
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- Digitalis/drugs for heart trouble? Yes No
- Nitroglycerin? Yes No
- Oral contraceptive/other hormonal therapy? Yes No

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- Sulfa drugs? Yes No
- Barbiturates, sedatives or sleeping pills? Yes No
- Aspirin? Yes No
- Iodine? Yes No
- Codeine/other narcotics? Yes No

Other _____

Have you had any serious trouble associated with any previous dental treatment? Yes No

If so, please explain _____

Do you have any disease, condition or problem not listed above that you think we should know about? Yes No

If so, please explain _____

Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? Yes No

Are you wearing contact lenses? Yes No

**Women:**

Are you pregnant? Yes No

Do you have any problem associated with your menstrual period? Yes No

Chief Dental Complaint:

_____

Signature of patient

**East** | 10311 E. Stonegate Ln. | Wichita, KS 67206 | *tel* 316.683.6518 | *fax* 316.683.0918 | *toll-free* 1.800.794.1818
**West** | 9909 W. 21st Street N. | Wichita, KS 67205 | *tel* 316.722.0857 | *web* www.toothmovers.org
**Derby** | 1821 E. Madison Ave., Ste. 1300 | Derby, KS 67037 | 316.683.6518