Orthodontic Associates
Smiling Faces, Beautiful Braces

Dr. Neal Patel, DMD, MS
1610 E. Marion St, Suite 200
Shelby, NC 28150
www.shelbyncortho.com
704-482-8934

YOUTH WELCOME FORM

Date_____

Patient name _____ Preferred Name _____

Gender _____ Age _____ Birth date _____

School _____ Hobbies/Sports _____

Home Address *(city, state, zip)* _____

Whom may we thank for recommending our office to you? _____

Past or Present Family Members in Treatment _____

Have you consulted an orthodontist previously? _____

Financial Information

Financially Responsible Party _____ Relationship to patient _____

Address *(city, state, zip)* _____

Best number to be contacted at _____ Occupation_____

Medical/Dental History

Dentist _____ Date of last Dental cleaning _____

Past or current history of Smoking or Tobacco use? ☐ Yes ☐No

Now or in the past, has the patient had:

Yes	No		Yes	No	
☐	☐	Abnormal bleeding/Hemophilia	☐	☐	Epilepsy
☐	☐	AIDS/HIV+	☐	☐	Permanent teeth removed or congenitally missing teeth
☐	☐	Asthma/Breathing Problems	☐	☐	Severe head or face injuries
☐	☐	Bone/Joint Disorders	☐	☐	Frequent oral habits (sucking finger, tongue thrust, chewing pen, etc.)
☐	☐	Cancer/Chemotherapy/Radiation	☐	☐	Tooth grinding or clenching
☐	☐	Diabetes	☐	☐	Clicking, locking, or soreness in jaw joints (TMJ)

Please explain any items checked 'yes' above _____

_____

_____

_____

_____

See other side

Please list any other relevant medical conditions:

_____

_____

Patient taking any medications? Y N If yes, please list:

_____

_____

Please rate the following aspects of orthodontic treatment in terms of their importance to you:

1) The comfort of the appliances used

☐Not Important ☐Slightly Important ☐Moderately Important ☐Important ☐Very Important

2) Esthetic or clear appliances (clear braces vs metal braces vs clear aligners)

☐Not Important ☐Slightly Important ☐Moderately Important ☐Important ☐Very Important

3) Low monthly payments

☐Not Important ☐Slightly Important ☐Moderately Important ☐Important ☐Very Important

4) Ability to begin treatment within the next 30 days

☐Not Important ☐Slightly Important ☐Moderately Important ☐Important ☐Very Important

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I, the undersigned, have given the above information and certify that it is accurate. I have also received a copy of the Notice of Privacy Practices for Orthodontic Associates.

Parent/Guardian Signature _____

Relationship to patient _____ Date _____

I authorize the release of medical, dental, and/or financial information to the following:

1. _____ Relationship to Patient: _____

2. _____ Relationship to Patient: _____

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