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IF PATIENT IS A CHILD

Name__________ Birthdate__________ Age__________

Address__________ City__________ State & Zip__________

Home Phone #__________ Emergency Phone #__________

Father's Name__________ Social Security #__________

Father's Employer__________ Business Phone #__________

Mother's Name__________ Social Security #__________

Mother's Employer__________ Business Phone #__________

Send statements to__________ Address__________

City__________ State & Zip__________

Dental Insurance ____ Yes ____ No Please Name__________

____

Family Dentist__________ Physician__________

Referred by__________

Siblings: None____ # of Sisters____ # of Brothers____

Home Phone Number__________ Emergency Phone #__________

Employer__________ Business Phone #__________

Spouse's Name__________ Social Security #__________

Spouse's Employer__________ Business Phone #__________

Dental Insurance ____Yes ____No Please Name__________

Family Dentist__________ Physician__________

Referred by__________

MEDICAL & DENTAL HISTORY

Present Health: Good Fair Poor Under Treatment: Yes No

Specify:__________

Present Drugs or Medication: Yes No

Specify:__________

Has patient been under care of physician during the past two years, other than for routine examination? Yes No

Birth Defects: Yes No

Specify:__________

Has patient reached puberty (menstruation, hair)? Yes No

)oes the patient have a material allergy (metal, latex, wool, chemicals, etc.)?______________

Have allergies to: Seasonal grasses______________ Food______________

Drugs______________ Other______________

Snore when sleeping? YES NO

Breath through mouth? Seldom Sometimes Usually

Have frequent sore throats? YES NO

Difficulty in swallowing and or chewing? YES NO

Pain or clicking in jaw? YES NO

Has the patient received medical treatment from an allergist or ear, nose and throat specialist? YES NO

IF YES: When:______________ By Whom:______________

Tonsils removed:______________ Adenoids removed:______________

Have any teeth been injured due to accidents or blows to the mouth? YES NO

Has patient received or been requested to receive speech correction? YES NO

The following habits are of interest to the orthodontist:

Thumb sucking until age______ Grinding of teeth YES NO

Finger sucking until age______ Tongue thrusting YES NO

Lip-biting / sucking YES NO Other habits______________

Has the patient had any unusual dental experiences?______________

____

Has the patient had previous orthodontic consultation or treatment? YES NO Date:__________ Dr:______________

Why did patient seek orthodontic treatment?______________

____

PLEASE INDICATE YES OR NO FOR ANY CONDITION EVEN IF YOU NO LONGER HAVE THEM (ALL INFORMATION IS CONFIDENTIAL)

Condition			Condition		
Heart Problems	YES	NO	Epilepsy	YES	NO
Describe______________			Liver Disease	YES	NO
Heart Murmur	YES	NO	Hepatitis	YES	NO
Thyroid Disorder	YES	NO	Kidney Disease	YES	NO
Arthritis	YES	NO	Cancer	YES	NO
Mitral Valve			Frequent Headaches	YES	NO
Prolapse	YES	NO	Herpes	YES	NO
Asthma	YES	NO	Sinus Trouble	YES	NO
Tuberculosis	YES	NO	Rheumatic Fever	YES	NO
Strep Throat	YES	NO	Head / Face Injury	YES	NO
Emotional Problems	YES	NO	Hearing Disorder	YES	NO
Anemia / Blood Disease	YES	NO	ADH or ADD	YES	NO
Immune System Problems	YES	NO	AIDS	YES	NO

Are there any other medical, dental or surgical problems not covered above? YES NO

Specify:______________

____

Additional comments you wish to make:______________

____

Signature of individual completing form______________

Relationship to patient______________ Today's Date______________