

DATE: _____

Patient's Name _____ Birthdate _____ Age _____

Home Address _____ City _____ State _____ Zip _____

E-mail _____ School _____ Grade _____

Patient's Dentist _____ Physician _____ Referred by _____

Father's Name _____ Occupation _____

Phone: Home _____ Cell _____ Work _____ Prefer: H C W

Mother's Name _____ Occupation _____

Phone: Home _____ Cell _____ Work _____ Prefer: H C W

Are parents divorced? YES NO Other circumstances: _____ # Children in Family _____

Responsible Party (designate only ONE person) _____ Relationship _____

I authorize financial and treatment information to be shared with other parent and/or legal guardian. YES NO

SIGNATURE _____

MEDICAL HISTORY

- 1. Is patient in good health? _____ YES NO
- 2. Has patient reached puberty? _____ YES NO
- 3. Are height and weight normal for age? _____ YES NO
- 4. Frequent colds, sore throat, or ear infections? _____ YES NO
- 5. Have tonsils and/or adenoids been removed? If YES, at what age? _____ YES NO
- 6. Any allergies or drug sensitivity? If YES, list _____ YES NO

6a. LATEX ALLERGY? YES / NO

6b. NICKEL ALLERGY? YES / NO

- 7. Any history of major illness? If YES, list _____ YES NO
- 8. Taking medication now? If YES, list _____ YES NO
- 9. Under medical care now? If YES, list _____ YES NO
- 10. Any implanted medical device? (ex: cochlear implant, pacemaker, etc.) If yes, list: _____ YES NO
- 11. Circle any of the following for which the patient has been diagnosed and/or treated:

Arthritis	Joint Replacement	Brain Injury	Prolonged Bleeding	HIV/AIDS	Cancer	Epilepsy	Sensory Disorders
Asthma	Rheumatic Fever	Heart Trouble	Endocrine Problems	Hepatitis	Tuberculosis	Diabetes	Nervous Disorders

DENTAL HISTORY

- 12. Date of last dental exam _____ Is dental work complete? _____ YES NO
- 13. Have full mouth x-rays ever been taken? If YES, give date _____ YES NO
- 14. Have there been any injuries to the face, mouth or teeth? _____ YES NO
- 15. Has the patient ever sucked thumb or fingers? If YES, until what age _____ YES NO
- 16. Has patient ever had oral habits such as lip biting or tongue thrusting? _____ YES NO
- 17. Does patient have any speech problems? _____ YES NO
- 18. Has patient ever had any speech therapy? _____ YES NO
- 19. Is the patient a mouth breather while asleep or awake? _____ YES NO
- 20. Are you aware of any missing or extra permanent teeth? _____ YES NO
- 21. Has an orthodontist been consulted previously? _____ YES NO
- 22. Have either parent or other children had orthodontic treatment _____ YES NO
- 23. List any musical instruments played _____
- 24. What are you or your dentist most concerned about? _____

25. Person filling out this form _____

26. Opt In to Text Message Appointment Reminders? YES NO