Date: _____

Patient's Name _____ Birth Date _____ Age _____

Home Address _____City_____State_____Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail_____ Referred by _____

Occupation _____ Employed by _____

Dentist _____ Physician _____

Person Financially Responsible _____ Relationship _____

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Have tonsils and/or adenoids been removed? . . . . . If yes, at what age? _____ Yes No
3. Frequent colds, sore throat, or ear infections? ..... No Yes
4. Any allergies or drug sensitivity? If yes, list: _____ No Yes

   4a. **LATEX? YES / NO** 4b. **NICKEL? YES / NO**
5. Any history of major illness? If yes, list: _____ No Yes
6. Taking medication now? If yes, list: _____ No Yes
7. Under medical care now? If yes, list: _____ No Yes
8. Any implanted medical device? (ex: cochlear implant, pacemaker, etc.) If yes, list: _____ No Yes
9. Circle any of the following for which you have been diagnosed and/or treated:

Asthma	Diabetes	Endocrine problem	Prolonged bleeding	Heart trouble	AIDS / HIV	Rheumatic fever
Epilepsy	Arthritis	Joint replacement	Nervous disorders	Brain injury	Hepatitis	Tuberculosis
		Osteoporosis	Sensory disorders	Cancer		

DENTAL HISTORY

10. Date of last dental exam _____ Is work complete? ..... Yes No
11. Have full mouth x-rays ever been taken? . . . . . If yes, give date _____ Yes No
12. Have there been any injuries to the face, mouth, or teeth? ..... No Yes
13. Have you ever sucked thumb or fingers? ..... If yes, until what age? _____ No Yes
14. Any oral habits, such as lip biting or tongue thrusting? ..... No Yes
15. Any finger nail biting? ..... No Yes
16. Are you aware of any missing or extra permanent teeth? ..... No Yes
17. Has an orthodontist been consulted previously? ..... No Yes
18. Would you consider your diet high in sweets? ..... No Yes
19. What are you or your dentist most concerned about? _____

_____

Your Signature_____