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 ____

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