

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 _____