



NAME YOU WANT TO BE CALLED _____

NAMES OF OTHER FAMILY MEMBERS WE TREATED _____

NAMES AND AGES OF OTHER CHILDREN IN THE FAMILY _____

PATIENT INFORMATION

GENDER - M / F

PATIENT'S NAME _____ DATE _____
Last First Middle

ADDRESS _____
Street City State Zip

HOME PHONE _____ BIRTH DATE _____ AGE _____ PATIENT'S SCHOOL _____

E-MAIL ADDRESS FOR APPOINTMENT REMINDERS _____

IF PATIENT IS A MINOR, GIVE PARENT'S OR GUARDIAN'S NAME _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

RESPONSIBLE PARTY INFORMATION

NAME _____
Last First Middle

RESIDENCE _____
Street City State Zip

MAILING ADDRESS _____
Street City State Zip

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____

PREVIOUS ADDRESS (IF LESS THAN 3 YRS.) _____
Street City State Zip

SOCIAL SECURITY # _____ BIRTH DATE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ # YRS. EMPLOYED _____

SPOUSE'S NAME _____ RELATIONSHIP TO PATIENT _____
Last First Middle

EMPLOYER _____ OCCUPATION _____ # YRS. EMPLOYED _____

SOCIAL SECURITY # _____ BIRTH DATE _____ WORK PHONE _____

DENTAL HISTORY

	<u>YES</u>	<u>NO</u>
PATIENT'S DENTIST _____ LAST SEEN _____		
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____	<input type="checkbox"/>	<input type="checkbox"/>
HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? _____ UNTIL WHAT AGE? _____	<input type="checkbox"/>	<input type="checkbox"/>
DOES THE PATIENT HAVE ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR EARS? _____	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____	<input type="checkbox"/>	<input type="checkbox"/>
HAS THE PATIENT HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS? _____	<input type="checkbox"/>	<input type="checkbox"/>
HAS THE PATIENT HAD ANY ORTHODONTIC TREATMENT? _____	<input type="checkbox"/>	<input type="checkbox"/>
IF SO, WHAT AGE? _____	<input type="checkbox"/>	<input type="checkbox"/>
DOES THE PATIENT CLENCH OR GRIND HIS/HER TEETH? _____	<input type="checkbox"/>	<input type="checkbox"/>
IS THE PATIENT ESPECIALLY APPREHENSIVE TOWARD DENTAL VISITS? _____	<input type="checkbox"/>	<input type="checkbox"/>
DOES THE PATIENT HAVE ANY CONGENITAL ABNORMALITIES? _____	<input type="checkbox"/>	<input type="checkbox"/>
LIST SPORTS AND INTEREST _____	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

HAS THE PATIENT EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE OR THYROID	<input type="checkbox"/>	<input type="checkbox"/>
PNEUMONIA	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	PROLONGED BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	LIVER INVOLVEMENT	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	FAINING OR DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>
BONE DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY INVOLVEMENT	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUS DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>

	<u>YES</u>	<u>NO</u>
HAVE YOU EVER BEEN TREATED FOR CANCER? _____	<input type="checkbox"/>	<input type="checkbox"/>
IS THE PATIENT IN GOOD HEALTH? _____	<input type="checkbox"/>	<input type="checkbox"/>
LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASON. _____ _____		
DOES THE PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____	<input type="checkbox"/>	<input type="checkbox"/>
LIST ANY ALLERGIES OR DRUG SENSITIVITY _____	<input type="checkbox"/>	<input type="checkbox"/>
HAVE TONSILS AND ADENOIDS BEEN REMOVED? _____ WHAT AGE? _____		
GROWTH IN THE PAST 6 MONTHS _____ HAS PATIENT REACHED PUBERTY? _____	<input type="checkbox"/>	<input type="checkbox"/>
HEIGHT: PATIENT'S _____ MOTHER'S _____ FATHER'S _____	<input type="checkbox"/>	<input type="checkbox"/>
PATIENT'S PHYSICIAN _____ LAST SEEN _____	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU TAKEN ANY MEDICATIONS FOR OSTEOPOROSIS IN THE PAST 3 YEARS? _____	<input type="checkbox"/>	<input type="checkbox"/>
IF SO, CIRCLE - FOSAMAX ACTONEL MIACALCIN BONIVA OTHER _____		

INSURANCE INFORMATION

INSURED'S NAME _____ INSURED'S SOC. SEC. # _____

INSURANCE COMPANY _____ GROUP # _____ LOCAL # _____

INSURANCE CO. ADDRESS _____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

COMPLETE ADDRESS _____ PHONE _____

I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

SIGNATURE (PARENT'S SIGNATURE IF MINOR) _____

UPDATES (DATE & INITIAL) _____