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PLEASE PRINT

DATE _____ NO. _____

PATIENT INFORMATION

LAST NAME	FIRST NAME	NICKNAME	S.S. NUMBER	SEX	BIRTHDATE	AGE

MAILING ADDRESS	CITY	STATE	ZIP	PHONE

SCHOOL (if a student)	GRADE		EMPLOYED BY/OCCUPATION	BUSINESS PHONE

REFERRED BY	NAME OF GENERAL DENTIST	DATE OF LAST VISIT

RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE	NAMES AND AGES OF OTHER CHILDREN

DOES PATIENT HAVE ORTHODONTIC INSURANCE? O YES O NO	PATIENT'S INTERESTS AND ACTIVITIES

PARENT INFORMATION (if patient is a minor)

FATHER'S NAME		MAILING ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER		PHONE	OCCUPATION/EMPLOYED BY	BUSINESS PHONE

MOTHER'S NAME		MAILING ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER		PHONE	OCCUPATION/EMPLOYED BY	BUSINESS PHONE

MEDICAL HISTORY

Please check (✓) if patient has or has had:

- O Joint swelling
- O Bone disorders
- O Heart Trouble
- O Heart Murmur
- O Mitral valve prolapse
- O Rheumatic fever
- O Thyroid problems
- O Diabetes
- O Hepatitis
- O Nervous disorders
- O Brain injury
- O Tuberculosis
- O Anemia
- O Asthma
- O Epilepsy
- O Arthritis
- O AIDS
- O Prolonged bleeding
- O Faintness/ Dizziness
- O Tonsils removed
- O Adenoids removed
- O Sore throats
- O Tonsillitis
- O Earaches

Has patient ever been hospitalized? O YES O NO
If YES, for what reason?

List any serious illnesses:

List any allergies:

List drugs or medications now being taken:

Is patient under physician's care presently? O YES O NO
If YES, for what reason?

Name of Physician:

DENTAL HISTORY

Please check (✓) if patient has or has had:

- O Any injuries to face, mouth, teeth? (circle)
- O Thumb, finger, lip sucking? (circle)
- O Any missing permanent teeth?
- O Any speech problems?
- O Any difficulty in swallowing or chewing?
- O Any pain or clicking on opening mouth?
- O Does patient visit dentist regularly? Date of last dental visit? _____
- O Has an orthodontist been consulted previously? Reason:

What is your reason for seeking orthodontic treatment?

Patient's attitude toward orthodontic treatment: (circle one)

Very motivated Will cooperate if needed Not motivated

Any other information that would be helpful to us:

Signature of Patient or of Parent or Guardian if Patient is a Minor

Updated: _____ _____ _____