PATIENT DATA

Patient name _____ Date _____

Birthdate _____ Age _____ Sex _____ Phone _____

Email _____ Cell _____

Address _____
street *city* *zip code*

Physician _____ Date of last visit to physician _____

Dentist _____ Date of last visit to dentist _____

Whom may we thank for referring you to us? _____

Do you anticipate a move or transfer in the next 6 to 12 months? _____

Does the patient have orthodontic insurance? (if yes, list carrier) _____

Describe your reason for seeking treatment _____
_____
_____

For patients over 18 years of age:

Occupation _____ Employer _____

Employer's address _____ Phone _____

Emergency contact _____ Relationship _____ Phone _____

Person responsible for account _____ Marital status _____

For patients under 18 years of age:

Patient's school _____

Father's name _____ Occupation _____

Employer _____ Phone _____

Address _____

Mother's name _____ Occupation _____

Employer _____ Phone _____

Address _____

Person responsible for account _____

Father or mother's address if different from patient _____

MEDICAL HISTORY

Patient Name _____

Please check yes (Y) if you have or have ever had any of the following conditions, and no (N) if not.

	Y	N		Y	N
Previous orthodontic treatment			Shortness of breath		
Dental problems other than routine care			Sinus trouble		
Tooth extractions (removal)			Smoker or smokeless tobacco		
Negative reaction to dental care			Seasonal allergy		
Injury to face or mouth			Allergy to medication		
Jaw pain			Hives or rash		
Difficulty moving jaw			Other allergy		
Difficulty chewing			Mumps		
Difficulty swallowing			Chickenpox		
Gag easily			Venereal disease		
Suck your thumb or fingers			Fainting or dizziness		
Play a musical instrument			Thyroid or other endocrine disorder		
Tonsils or adenoids removed			Frequent headaches		
Speech impairment			Epilepsy or seizures		
Heart condition			Emotional or nervous disorder		
Congenital heart defect			Psychiatric care		
Rheumatic fever			Severe weight loss or gain		
Chest pains			Diabetes		
Swollen ankles			Kidney or liver disease		
Stroke			Ulcers		
Bleeding problems			Scarlet fever		
High or low blood pressure			Ear pain or infection		
Anemia			Hearing impairment		
Artificial valves or joints			Glaucoma		
Blood transfusion			Arthritis		
Compromised Immune system			Cancer or tumor		
HIV or AIDS			Major surgery		
Lung Disease			Birth Defects		
Asthma			Recurrent illness		
Bronchitis			Taking *any* medications or supplements		
Emphysema			**FEMALES ONLY:**		
Pneumonia			Reached menses		
Tuberculosis			In menopause		
Frequent colds or sore throat			Using birth control medication		
Persistent cough			Pregnant		

HISTORY GIVEN BY: _____ DATE: _____

Doctor's Notes:

_____

_____

_____

_____

_____

_____

_____

_____