

**PATIENT INFORMATION**

Last Name	First Name	Child Goes By	S.S. Number	Sex	Date of Birth	Age
Address		City	State	Zip	Home Phone	
School (If a Student)		Grade	Is the patient adopted?		Cell Phone	
Email Address:						Add to Mailing List <input type="checkbox"/>
Siblings (Name and Age)			Hobbies/Interests			
Referred By		Name of General Dentist			Date of Last Visit	

**PARENT INFORMATION**

Father's Name	single <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> widow(er) <input type="checkbox"/>	Mailing Address	City	State	Zip	Home Phone
Social Security No.		Birthdate	Employed By/Occupation		Cell Phone	Business Phone
Mother's Name	single <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> widow(er) <input type="checkbox"/>	Mailing Address	City	State	Zip	Home Phone
Social Security No.		Birthdate	Employed By/Occupation		Cell Phone	Business Phone
E-Mail Address:						Add to Mailing List <input type="checkbox"/>

**INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT**

Name	Relationship to Patient	Employed By/Occupation	Phone
Mailing Address		City	State
		Zip	Business Phone
Spouse's Name	Employed By/Occupation		Phone

**MEDICAL / DENTAL HISTORY**

<p>Is the patient in good health? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does the patient have any history of major illness? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>_____</p> <p>Has the patient ever been under the care of a physician? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Please list: _____</p> <p>Has there been any injuries to the face, mouth, or teeth? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>_____</p> <p>Has the patient ever sucked a thumb or fingers? At what age? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>_____</p> <p>Does the patient have any speech problems? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is the patient a mouth breather? While awake? While asleep? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Have you been informed of any missing or extra permanent teeth? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Has either parent had orthodontic treatment? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Has an orthodontist been consulted previously? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Has the patient reached puberty? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Girls - Has she started menstruation? At what age? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Boys - Has his voice changed? At what age? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Have tonsils and adenoids been removed? What age? _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Height: _____ Weight: _____</p>	<p style="text-align: center;"><i>Please check any of the following conditions or problems.</i></p> <table style="width: 100%;"> <tr> <td>Asthma <input type="checkbox"/></td> <td>Fainting/dizziness <input type="checkbox"/></td> </tr> <tr> <td>Bone (fracture) <input type="checkbox"/></td> <td>Hearing <input type="checkbox"/></td> </tr> <tr> <td>Seizures <input type="checkbox"/></td> <td>Heart Trouble <input type="checkbox"/></td> </tr> <tr> <td>Diabetes <input type="checkbox"/></td> <td>Kidney Trouble <input type="checkbox"/></td> </tr> <tr> <td>Endocrine (Hormone) <input type="checkbox"/></td> <td>Liver Trouble <input type="checkbox"/></td> </tr> <tr> <td>Epilepsy <input type="checkbox"/></td> <td>Mumps <input type="checkbox"/></td> </tr> <tr> <td>Emotional Disorder <input type="checkbox"/></td> <td>Rheumatic Fever <input type="checkbox"/></td> </tr> <tr> <td>Excessive bleeding <input type="checkbox"/></td> <td>Speech Disorder <input type="checkbox"/></td> </tr> <tr> <td>Eye <input type="checkbox"/></td> <td>Tuberculosis <input type="checkbox"/></td> </tr> <tr> <td>AIDS <input type="checkbox"/></td> <td>Hepatitis <input type="checkbox"/></td> </tr> </table> <p>Other: _____</p> <p>_____</p> <p>List any drugs or medications now being taken. Give reasons: _____</p> <p>_____</p> <p>_____</p> <p>List any allergies or drug sensitivity: _____</p>	Asthma <input type="checkbox"/>	Fainting/dizziness <input type="checkbox"/>	Bone (fracture) <input type="checkbox"/>	Hearing <input type="checkbox"/>	Seizures <input type="checkbox"/>	Heart Trouble <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Kidney Trouble <input type="checkbox"/>	Endocrine (Hormone) <input type="checkbox"/>	Liver Trouble <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Mumps <input type="checkbox"/>	Emotional Disorder <input type="checkbox"/>	Rheumatic Fever <input type="checkbox"/>	Excessive bleeding <input type="checkbox"/>	Speech Disorder <input type="checkbox"/>	Eye <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	AIDS <input type="checkbox"/>	Hepatitis <input type="checkbox"/>
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Do you have orthodontic insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of Company? _____	Policy # _____																				

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of the account.

\_\_\_\_\_  
Signature (parent if patient is a minor)