Date _____

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Orthodontist

CONFIDENTIAL PATIENT INFORMATION

Patient _____ Nickname _____
Age _____ Birthdate _____ Sex _____ Home Phone _____
Home Address/Street _____ City _____ Zip _____
School (if student) _____ Grade _____
Other Children in family/Ages _____
_____

Father's Name _____ Soc. Sec. # _____ Birthdate _____
Home Address (if different) _____ City _____ Zip _____
Employer _____ Office Ph _____
Insurance Carrier _____ Plan Name _____ Group # _____

Mother's Name _____ Soc. Sec. # _____ Birthdate _____
Home Address (if different) _____ City _____ Zip _____
Employer _____ Office Ph _____
Insurance Carrier _____ Plan Name _____ Group # _____

Dentist's Name _____ Address _____
Physician Name _____ Address _____
Has patient had orthodontic treatment? _____ if so, by whom _____
What is your main concern in seeking this appointment? _____
Who referred you to our office? _____
Musical instruments played? _____

Is the patient under the care of a physican? [ ] yes [ ] no
If so, what is the condition being treated? _____
Has there been any change in your health in the last year? [ ] yes [ ] no
Has the patient had any injury to the face, teeth, or jaws? [ ] yes [ ] no
Date of last physical exam? _____ Immunized? Date: _____ [ ] yes [ ] no
Has the patient had any serious illness or operation? [ ] yes [ ] no
If so, what was the illness or operation? _____
Is the patient presently taking any medication (prescription or over the counter)? [ ] yes [ ] no
If so, what and for what condition? _____
Has the patient ever had a reaction to any medication? [ ] yes [ ] no
If so, what medication and describe the reaction? _____
Females: Mensus, at what age? _____ Are you pregnant? [ ] yes [ ] no
Has the patient ever had any serious problem associated with any previous dental treatment? [ ] yes [ ] no
If so, explain _____
Has the patient ever had any of the following diseases or problems?
Check all that apply:

[ ] Congential Heart Disease
[ ] Hepatitis, Jaundice, Liver Disease
[ ] Tonsils Removed
[ ] Cardiovascular Disease
[ ] Convulsions/Seizures
[ ] Mental Illness
[ ] Bleeding Disorders
[ ] Anemia
[ ] Allergy
[ ] Pacemaker/Cardiac Valves
[ ] Arthritis
[ ] Radiation Treatment/Chemotherapy
[ ] Kidney or Urinary Disorders
[ ] SoreThroats/Sinus Problems
[ ] Asthma or Hay Fever
[ ] Heart Murmur
[ ] Diabetes
[ ] Learning Disability
[ ] Respiratory Disease
[ ] HIV/Aids
[ ] Rheumatic Fever
[ ] Tuberculosis
[ ] Speech/Hearing Problems
[ ] Digestive Disorders
[ ] Venereal Disease
[ ] Cleft Lip/Palate

Does the patient have any disease, condition, or problem not listed above that you think I should know about? [ ] yes [ ] no
If so, explain _____
Remarks:

_____
Signature of Parent or Guardian/Date