



Date \_\_\_\_\_ 20\_\_\_\_\_ S.S.# \_\_\_\_\_  
 Patient \_\_\_\_\_ Age \_\_\_\_\_ Sex: Male  Female   
 Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ School Attending \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Father \_\_\_\_\_ Phones(H) \_\_\_\_\_ (C) \_\_\_\_\_ S.S.# \_\_\_\_\_  
 Father's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Father's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Mother \_\_\_\_\_ Phones (H) \_\_\_\_\_ (C) \_\_\_\_\_ S.S.# \_\_\_\_\_  
 Mother's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Mother's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Guardian \_\_\_\_\_ Phones (H) \_\_\_\_\_ (C) \_\_\_\_\_ S.S.# \_\_\_\_\_  
 Guardian's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Closest Relative (other than parent or guardian) \_\_\_\_\_ Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Person Responsible for Account \_\_\_\_\_ Phones (H) \_\_\_\_\_ (C) \_\_\_\_\_ S.S.# \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Orthodontic Insurance Yes  No  What Company? \_\_\_\_\_  
 Patient's Regular Dentist \_\_\_\_\_ Date of last check-up \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_  
 What do you think is the patient's orthodontic problem? \_\_\_\_\_  
 What do you hope orthodontics will accomplish? \_\_\_\_\_

Is the patient in good health? Yes  No  Explain: \_\_\_\_\_  
 Any major or unusual illnesses? Yes  No  Explain: \_\_\_\_\_  
 Currently being treated by physician? Yes  No  Reason: \_\_\_\_\_  
 Currently taking medication? Yes  No  Names & Reasons: \_\_\_\_\_  
 Allergies Yes  No  List: \_\_\_\_\_  
 Drug Sensitivity Yes  No  List: \_\_\_\_\_

Please check if patient has or had any of the following:

Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>
<input type="radio"/> Anemia	<input type="radio"/> Hepatitis	<input type="radio"/> Endocrine Problems	<input type="radio"/> Is the patient in a risk group for AIDS?
<input type="radio"/> Blood Disease	<input type="radio"/> Bone Disorders	<input type="radio"/> Glaucoma	<input type="radio"/> Tonsils Removed: Age: _____
<input type="radio"/> Prolonged Bleeding	<input type="radio"/> Epilepsy	<input type="radio"/> Heart Problems	<input type="radio"/> Adenoids Removed: Age: _____
<input type="radio"/> Jaundice	<input type="radio"/> Herpes	<input type="radio"/> Tuberculosis	<input type="radio"/> Asthma
<input type="radio"/> Rheumatic Fever	<input type="radio"/> Frequent Colds or Flu	<input type="radio"/> Diabetes	<input type="radio"/> Mouthbreathing: While awake? <input type="radio"/>
<input type="radio"/> Scarlet Fever	<input type="radio"/> Tonsillitis	<input type="radio"/> Adenitis	While asleep? <input type="radio"/>

Names and ages of brothers and sisters: \_\_\_\_\_ Have any had orthodontic treatment? Yes  No   
 By whom? \_\_\_\_\_  
 Yes  No  Has the patient had any severe head or face injuries? Explain: \_\_\_\_\_  
 Has the patient had a history of thumb sucking or finger sucking? Stopped? Yes  No  When? \_\_\_\_\_  
 Does the patient play any musical (wind) instruments? What? \_\_\_\_\_  
 Has the patient consulted or been treated by an orthodontist previously? Yes  No  By whom? \_\_\_\_\_

Does the patient have a history of:

<input type="radio"/> Clenching teeth	<input type="radio"/> Grinding teeth	<input type="radio"/> Headaches (more than normal)	<input type="radio"/> Muscular soreness around the head and neck
<input type="radio"/> Jaw joint soreness	<input type="radio"/> Jaw joint clicking	<input type="radio"/> Jaw joint popping	<input type="radio"/> Ringing in the ears

Any other helpful information: \_\_\_\_\_ Med. History Updates \_\_\_\_\_

Signature of patient (or parent of a minor): \_\_\_\_\_

