

Date _____

Patient# _____

PATIENT INFORMATION

Name _____ Preferred Name _____
Sex ___ M ___ F Birthdate _____ Age ___ Home Phone# _____
Address _____ City _____ State _____ Zip _____
Patient's School _____ Patient's Grade _____
Height _____ Weight _____
Father's Name _____ Employed by _____
Business Address _____ Occupation _____
Business Phone # _____ Social Security # _____ DOB _____
Name of Dental Insurance Company _____
Mother's Name _____ Employed by _____
Business Address _____ Occupation _____
Business Phone # _____ Social Security # _____ DOB _____
Name of Dental Insurance Company _____

Medical History

Dentist's Name _____ Date of Cleaning _____

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following?

Heart Problems _____	Epilepsy _____	Special Diet _____
High Blood Pressure _____	Headaches _____	Swollen Neck Glands _____
Low Blood Pressure _____	Hepatitis, Jaundice _____	Rheumatic Fever _____
Circulatory Problems _____	Liver Disease _____	Sinus Problems _____
Nervous Problems _____	Cancer _____	A.I.D.S. or Immuno- suppressive Disorders _____
Radiation Treatment _____	Psychiatric Care _____	Stroke _____
Artificial Heart Valves _____	Chronic Diarrhea _____	Ulcer _____
Recent Weight Loss _____	Allergies to Anesthetics _____	Hemophilia _____
Back Problems _____	Allergies to Medicine _____	Chemical Dependency _____
Diabetes _____	General Allergies _____	Venereal Disease _____
Respiratory Disease _____	Blood Disease _____	

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____

If so, what _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what? _____

Are you under the care of a physician? _____ yes _____ no

(Women) Do you suspect that you are pregnant? _____ yes _____ no Menstruation _____ yes _____ no

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____