PATIENT'S NAME	☐ MALE ☐ FEMALE	BIRTHDATE			When answered by s		
ADDDESO (OT)		0174 07475 710			DO YOU OR HAVE YOU EVER HAD:	MED	IC
ADDRESS (ST)		CITY, STATE, ZIP				YES	1
HOME PHONE	CELL PH #/CARRIER	PATIENT'S S.S.# (IF ADL	JLT)		HEPATITIS/LIVER PROBLEMS		Г
		(,		ALLERGY TO PENICILLIN		Γ
PLACE OF EMPLOYMENT (IF ADULT)	WORK PHONE	SCHOOL NAME			ALLERGY TO LATEX		Γ
					ALLERTY TO NICKEL/METALS		L
SPECIAL INTERESTS	WHAT (IF ANY) MUSICA	AL INSTRUMENT IS PLAYE	D?		DIABETES		L
					EPILEPSY/SEIZURES		L
IF MINOR	, COMPLETE THE FO	OLLOWING:			ASTHMA		L
FATHER'S NAME		ADDRESS (ST.)			BREATHING PROBLEMS		L
					HAY FEVER/ALLERGIES SINUS PROBLEMS		H
HOME PHONE	CELL PH #/CARRIER	CITY, STATE, ZIP			HEART CONDITIONS/MURMUR		H
OCCUPATION		WILEDE EMBLOVED			BLEEDING PROBLEMS/ANEMIA		H
OCCUPATION		WHERE EMPLOYED			OSTEOPOROSIS		H
WORK PHONE		FATHER'S S.S.#			ORAL OR IV BIOPHOSPHONATE		F
WOUNTHOME		FAITHER 0 0.0.#		J	TREATMENT		
MOTHER'S NAME ☐ MRS. ☐ M	IS.	ADDRESS (ST.)		一	KIDNEY PROBLEMS		r
···		, ,		J	REACTION TO DRUGS		Γ
HOME PHONE	CELL PH #/CARRIER	CITY, STATE, ZIP			REACTION TO ANESTHETIC		l
					NERVE PROBLEMS		Γ
OCCUPATION		WHERE EMPLOYED			BACK OR NECK PROBLEMS		Ī
					MAJOR SURGERY		Ī
WORK PHONE		MOTHER'S S.S.#			ANY COMMENTS ON ANY OF THE ABO	VE UK U	IN
WHO WOULD BE RESPONSIBLE FOR	R THE ACCOUNT?	ADDRESS (ST.)					
					ARE YOU NOW UNDER THE CARE OF	A PHYS	IC
NAME OF INSURANCE CO. IF ORTHO	ODONTIC COVERAGE IS A	IVAILABLE			COMMENTS:	IZ ATION	_
NAME OF INCURED	INCURED D O D	COOLAL CEOUDITY NUM	ADED		HAVE YOU HAD ANY PAST HOSPITAL COMMENTS:	ZATION	0
NAME OF INSURED	INSURED D.O.B.	SOCIAL SECURITY NUI	MRFK		COMMENTS.		_
WOULD YOU LIKE TO RECEIVE YOUR	R APPOINTMENT CONFIR	MATION BY:				DEN	T
□ PHONE □ EMAIL OR □ T					DO YOU OR HAVE YOU EVER HAD:		_
	EXT						
HOME E-MAIL ADDRESS:					ANY PAST INJURY TO THE HEAD OR	FACE?	_
HOME E-MAIL ADDRESS: PRIMARY EMAIL (PATIENT/MOTHER/FATH	HER):				ANY PAST INJURY TO TEETH?		_
HOME E-MAIL ADDRESS:	HER): FATHER):	DATE			ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TREA	TMENT	_
HOME E-MAIL ADDRESS: PRIMARY EMAIL (PATIENT/MOTHER/FATH SECONDARY EMAIL (PATIENT/MOTHER/F	HER): FATHER):	DATE			ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TREA SPEECH THERAPY, TONGUE THRUST	TMENT	
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OUR OFFICE TODAY'S DATE:										
When answered by someone other than patient, "You" refers to patient. MEDICAL HISTORY										
DO YOU OR HAVE YOU EVER HAD:	-									
	YES	NO		YES	NO					
HEPATITIS/LIVER PROBLEMS			BIRTH DEFECTS							
ALLERGY TO PENICILLIN			MEASLES							
ALLERGY TO LATEX			MUMPS							
ALLERTY TO NICKEL/METALS			CHICKEN POX							
DIABETES			SPEECH PROBLEMS							
EPILEPSY/SEIZURES			SWALLOWING PROBLEMS							
ASTHMA			FAINTING							
BREATHING PROBLEMS			EYE DISORDER							
HAY FEVER/ALLERGIES			GLASSES/CONTACTS							
SINUS PROBLEMS			GLAUCOMA							
HEART CONDITIONS/MURMUR			ULCERS/COLITIS							
BLEEDING PROBLEMS/ANEMIA			HIV/AIDS							
OSTEOPOROSIS			PHYSICAL HANDICAP							
ORAL OR IV BIOPHOSPHONATE			MENTAL HANDICAP							
TREATMENT			TUBERCULOSIS							
KIDNEY PROBLEMS			HIGH BLOOD PRESSURE							
REACTION TO DRUGS			RHEUMATIC FEVER							
REACTION TO ANESTHETIC			EATING DISORDER							
NERVE PROBLEMS			ADD/ADHD							
BACK OR NECK PROBLEMS			TONSILS/ADENOIDS REMOVED							
MAJOR SURGERY			TAKING MEDICATIONS NOW							
ANY COMMENTS ON ANY OF THE ABO	VE OR C	N OTH	ER HEALTH MATTERS YOU WOULD LIKE	US TO K	NOW					
ARE YOU NOW UNDER THE CARE OF	A PHYS	ICIAN'	? YES • NO •							
COMMENTS:										
HAVE YOU HAD ANY PAST HOSPITAL	IZATION	NS?	YES NO							

DENTAL HISTORY						
DO YOU OR HAVE YOU EVER HAD:	YES	NO				
ANY PAST INJURY TO THE HEAD OR FACE?						
ANY PAST INJURY TO TEETH?						
ANY PREVIOUS ORTHODONTIC TREATMENT?						
SPEECH THERAPY, TONGUE THRUST THERAPY, OR MYOFUNCTIONAL THERAPY?						
ANY TOOTH SENSITIVITY?						
BLEEDING GUMS?						
AN UNFAVORABLE REACTION TO PAST MEDICAL OR DENTAL CARE?						
FREQUENT MOUTH ULCERS?						
ANY PREVIOUS EXTRACTIONS?						
RECENT DENTAL X-RAYS?						
HAS ANY NEAR RELATIVE EVER HAD FACIAL OR JAW SURGERY?						
HAS ANY NEAR RELATIVE EVER HAD A NOTICEABLE RECEEDING OR PROTUDING LOWER JAW?						
HAS ANYONE IN THE FAMILY HAD ORTHODONTIC TREATMENT?						
DO YOU SUCK YOUR FINGER OR THUMB? IF YES: INIGHT AND/OR ID DAY						
DO YOU EVER SUCK YOUR FINGER OR THUMB?						
DO YOU BITE OR SUCK ON THE INSIDE OF YOUR CHEEK?						
DO YOU BITE YOUR FINGERNAILS OR OTHER OBJECT?						
DO YOU GRIND YOUR TEETH? IF YES: ☐ NIGHT AND/OR ☐ DAY						
DO YOU CLENCH YOUR JAWS? IF YES: 🗖 NIGHT AND/OR 🗖 DAY						
IS YOUR DRINKING WATER AT HOME FLUORIDATED?						
DO YOU GET FLUORIDE TREATMENTS AT SCHOOL OR FROM YOUR DENTIST?						
HAVE YOU EVER HAD PERIODONTAL (GUMS) TREATMENT?						
HAVE YOU EVER HAD A ROOT CANAL?						
DO YOU FREQUENTLY CHEW CHEWING GUM?						
DO YOU ☐ SMOKE OR ☐ CHEW TOBACCO? IF YES, PLEASE INDICATE						
ARE YOU A MOUTH BREATHER?						
DO YOU SNORE?						