WELCOME TO OUR OFFICE

TODAY'S DATE_

| TIENT'S NAME MALE / FEMALE | BIRTHDATE | |
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| | | |
| DDRESS (ST.) | CITY, STATE, ZIP | DO YOU HAY |
| DME PHONE CELL PHONE | PATIENT'S S.S# (IF ADULT) | HEPATITIS |
| ACE OF EMPLOYMENT (IF ADULT) WOR | K PHONE SCHOOL NAME | ALLERGY T |
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| ECIAL INTERESTS WHAT (IF | ANY) MUSICAL INSTRUMENT IS PLAYED? | ALLERGY TO |
| | | DIABETES |
| IF MINOR, COMPLE | ETE FOLLOWING: | EPILEPSY |
| HER'S NAME | ADDRESS (ST.) | SEIZURES |
| | | ASTHMA |
| ME PHONE CELL PHONE | CITY, STATE, ZIP | BREATHING |
| | | HAY FEVER |
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| SINESS PHONE | FATHER'S S.S.# | BLEEDING |
| THER'S NAME MRS. MS. | ADDRESS (ST.) | ANEMIA |
| | ADDITEOU (OT.) | LIVER PROE |
| ME PHONE CELL PHONE | CITY, STATE, ZIP | KIDNEY PRO |
| | | REACTION T |
| CUPATION | WHERE EMPLOYED | REACTION T |
| | | NERVE PRO |
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| O WOULD BE RESPONSIBLE FOR THE ACC | COUNT? ADDRESS (ST.) | ANY COMMEN |
| AE OF INSURANCE CO. IF ORTHODONTIC | | |
| | COVERAGE IS AVAILABLE | |
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| When answered by | someone | other | than patient, "You" refer to patient | | |
|---|--|---|---|-----|----|
| - | MED | ICAL | HISTORY | | |
| DO YOU HAVE OR HAVE YOU HAD: | | | | | r— |
| | YES | NO | | YES | NC |
| | | | BIRTH DEFECTS | | |
| ALLERGY TO PENICILLIN ALLERGY TO LATEX | | | MEASLES | | - |
| ALLERGY TO NICKEL | | | CHICKEN POX | | |
| DIABETES | | | SPEECH PROBLEMS | | |
| EPILEPSY | | | SWALLOWING PROBLEMS | | - |
| SEIZURES | | | FAINTING | | - |
| ASTHMA | | | EYE DISORDER | | |
| BREATHING PROBLEMS | | | GLASSES/CONTACTS | | - |
| HAY FEVER/ALLERGIES | | | GLAUCOMA | - | - |
| SINUS PROBLEMS | | | ULCERS/COLITIS | | |
| HEART CONDITION/MURMUR | | | HIV/AIDS | | |
| BLEEDING PROBLEMS | | | | | - |
| ANEMIA | | | PHYSICAL HANDICAP | | |
| LIVER PROBLEMS | | | MENTAL HANDICAP | | |
| KIDNEY PROBLEMS | | | HIGH BLOOD PRESSURE | + | |
| REACTION TO DRUGS | | | RHEUMATIC FEVER | | |
| | | | | | |
| REACTION TO ANESTHETIC | | | EATING DISORDER | | |
| NERVE PROBLEMS | | | ADD/ADHD TONSILS/ADENOIDS REMOVED | | |
| MAJOR SURGERY | | _ | | | |
| | | | TAKING MEDICATIONS NOW | | |
| | | | | | |
| ARE YOU NOW UNDER THE CARE OF COMMENTS: HAVE YOU HAD ANY PAST HOSPITALI COMMENTS: | | | | | |
| COMMENTS: HAVE YOU HAD ANY PAST HOSPITALI | ZATIONS? | YES | | | |
| COMMENTS: HAVE YOU HAD ANY PAST HOSPITALI | ZATIONS? | YES | | YES | NO |
| COMMENTS: HAVE YOU HAD ANY PAST HOSPITALI COMMENTS: DO YOU HAVE OR HAVE YOU HAD ANY PAST INJURY TO THE HEAD O | ZATIONS? De | YES | | YES | NO |
| COMMENTS: HAVE YOU HAD ANY PAST HOSPITALI COMMENTS: DO YOU HAVE OR HAVE YOU HAD ANY PAST INJURY TO THE HEAD OI ANY PAST INJURY TO TEETH? | ZATIONS? DE R FACE? | YES | | YES | NO |
| COMMENTS: HAVE YOU HAD ANY PAST HOSPITALI COMMENTS: DO YOU HAVE OR HAVE YOU HAD ANY PAST INJURY TO THE HEAD OI ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TR | DE R FACE? EATMENT | YES | I NO I | YES | NO |
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