

CONFIDENTIAL Date____

PATIENT INFORMATION

Birthdate Age in years School (If applicable) Grade Parents or legal guardian (If applicable)	Name		Prefer to be called	I	Sex
Parients or legal guardian (If applicable)					
Patient's Address			\ \ 11		
PERSON RESPONSIBLE FOR ACCOUNT Name SS# Relationship Home Address City E-mail Home Address RESPONSIBLE PARTY # 2 (If more than one person is responsible for this account) Name SS# Relationship Business Phone Home Address RESPONSIBLE PARTY # 2 (If more than one person is responsible for this account) Name SS# Relationship Business Phone RESPONSIBLE PARTY # 2 (If more than one person is responsible for this account) Name SS# Relationship Birthdate RESPONSIBLE PARTY # 2 (If more than one person is responsible for this account) Name SS# Relationship Birthdate RESPONSIBLE PARTY # 2 (If more than one person is responsible for this account) Name SS# Relationship Birthdate RESPONSIBLE PARTY # 2 (If more than one person is responsible for this account) Name SS# Relationship Birthdate RESPONSIBLE PARTY # 2 (If more than one person is responsible for this account) Name SS# Relationship Birthdate RESPONSIBLE PARTY # 2 (If more than one person is responsible for this account) Name SS# Relationship Birthdate Relationship Birthdate RESPONSIBLE PARTY # 2 (If more than one person is responsible for this account) Name SS# Relationship Birthdate Rela			City		Zip
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Name	DESDONSIDI E DA DTV # 2 (If more th	an ana nargan is rasnansihl	a for this agount)		
Home Address City E-mail Family Phone () Cell Phone E-mail Employer Business Address Business Address Business Address Business Phone Is there another person who may bring patient to appointment? If so, please specify Do you grant us permission to discuss treatment progress with them? Emergency contact Permission to discuss treatment progress with them? Emergency contact Permitsion to discuss treatment progress with them? Emergency contact Permitsion to discuss treatment progress with them? Emergency contact Permitsion to discuss treatment progress with them? Emergency contact Permitsion to discuss treatment progress with them? Emergency contact Permitsion to discuss treatment progress with them? Emergency contact Permitsion to discuss treatment progress with them? Emergency contact Permitsion to discuss treatment progress with them? Emergency contact Permitsion to discuss treatment progress with them? Emergency contact Permitsion to discuss treatment progress with them? Family place to standards to the mail covered by orthodontic insurance? If yes, please name 1) 2) ENDENTAL QUESTIONNAIRE What is the main concern for this examination? Was anyone else in the patient's family treated in our office? Does the father have an orthodontic problem? Treated Mother Permitsion Ages Sisters Ages Is the patient adopted? How may brothers? Ages Sisters Ages Is the patient adopted? Height of patient Employers Ages Sisters Ages Is the patient adopted? However treated by a mother demitsion and the patient stemperament Hobbies or Sports Does orthe patient's temperament Hobbies or Sports Does the patient have any speech problems? Is the habit still present? Quit at age Aprit at the patient have any speech problems? While askeep? While askeep? While askeep? While askeep? While askeep? Is the patient currently experiencing any dental pain?	,			Relationship	Rirthdate:
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Is there another person who may bring patient to appointment? If so, please specify Do you grant us permission to discuss treatment progress with them? Emergency contact Family physician Family dentist Whom may we thank for referring you to this office? Is the patient covered by orthodontic insurance? If yes, please name 1) DENTAL QUESTIONNAIRE What is the main concern for this examination? Was anyone else in the patient's family treated in our office? Does the father have an orthodontic problem? Treated Mother Face and mouth most resembles: Father Mother Face and mouth most resembles: Father Mother Growth of patient last year Describe patient's temperament Father Musical instrument played Have there been any injuries to the face mouth or teeth? Has the patient ever sucked a thumb or fingers? Joes the patient have any speech problems? Is the patient a mouth breather? While awake? While asleep? When was the patient's last routine dental exam and cleaning? Is the patient currently experiencing any dental pain? Is the patient currently experiencing any dental pain?					
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Does the patient have a history of naving multiple cavities? Ponning of clicking of the law loint?					

Have you ever had or have you now? (Please check to the right of each item)

(Check each item)	YES	NO		YES	NO		YES	NO
Epilepsy or Seizures			Hemophilia			Ulcers		
Fainting or Dizziness			Bruise or Bleed easily			Kidney problems		
Nervousness			Heart problems or Angina			Diabetes		
Stroke			Hypertension			Thyroid problems		
Glaucoma			Rheumatic fever			AIDS or HIV +		
Cold sores/Fever blisters			Heart murmur			Arthritis		
Persistent cough			Mitral valve prolapse			Painful Joints (incl. Jaw)		
Emphysema			Congenital heart lesions			Prosthetic joints		
Tuberculosis/PPD positive			Prosthetic heart valve			Hives		
Asthma			Pacemaker			Steroid medications		
Hay fever			Blood transfusion (s)			Fear of dental treatment		
Sinus problems			Liver disease			Communication difficulties		
Frequent tonsillitis			Yellow jaundice			Mental Heath Disturbance		
Adenoid conditions			Hepatitis- type:			ADD/ADHD		
Osteoporosis			Gastric reflux			Anorexia/Bulimia		
Skin disorders			Hearing Loss			Depression		
Anemia			Ear Pain			Unexplained weight change		
Sickle Cell disease			Frequent headaches			Cancer or Tumor		
Birth defects			Neuromuscular disorders			Radiation/Chemotherapy		

ALLERGIES: (please specify)	Drugs or Medications								
	Metals	Latex	Vinyl	Aerylic					
	Animals	Foods	Other substances						
History of Hospitalizations:									
Operations:									
Medications Presently Taking:									
Does the patient smoke?	Use chewless tobacco?	Have or h	ad a substance abuse proble	m? (please specify)					
Is the patient currently being trea	ated by another health care pro-	fessional?	For?						
Does the patient have any other p	physical symptoms or medical	conditions not me	entioned?						
Does the patient have any specia	l needs?								
Women Only: Is the patient preg	gnant?Does she an	ticipate becoming	pregnant within the next two	o years?					
FAMILY MEDICAL HISTORY:	Do the patients parents or sib	lings have any of	the following? (please speci	fy):					
Bleeding Disorders	Diabetes		_Arthritis	Severe Allergies					
Heart disease	Seizures		Unusual dental problems						
Jaw size imbalance	Ot	her hereditary med	dical conditions						
Patient or Guardian's Signature	Date		Staff Member/Doct	or Signature	Date				
Patient or Guardian's Signature	Date		Staff Member//Doc	tor Signature	Date				









