

**WELCOME TO OUR OFFICE**

DATE \_\_\_\_\_  
Updated \_\_\_\_\_  
Updated \_\_\_\_\_

PATIENT'S NAME _____		NICKNAME _____	
D.O.B. _____	AGE _____	SEX M _____	F _____
ADDRESS _____		TOWN _____	STATE _____ ZIP _____
HOME PHONE: _____		Cell/Work PHONE _____	
OCCUPATION _____		EMPLOYED BY _____	
EMAIL _____			

PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_

GENERAL APPRAISAL Who can we thank for your referral? \_\_\_\_\_

CHIEF COMPLAINT (REASON FOR CONSULTATION) \_\_\_\_\_

HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT? \_\_\_\_NO \_\_\_\_YES IF YES,

EXPLAIN \_\_\_\_\_

**MEDICAL HISTORY**

PHYSICIAN \_\_\_\_\_ LAST EXAM \_\_\_\_\_

CURRENTLY UNDER MEDICAL TREATMENT \_\_\_\_NO YES\_\_ explain \_\_\_\_\_

HISTORY OF RECENT ILLNESS \_\_\_\_NO YES\_\_ explain \_\_\_\_\_

CURRENTLY TAKING MEDICATION \_\_\_\_NO YES\_\_ explain \_\_\_\_\_

EVER BEEN HOSPITALIZED \_\_\_\_NO YES\_\_ explain \_\_\_\_\_

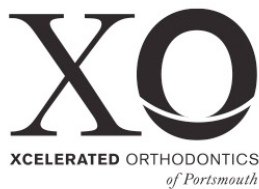
EVER HAD AN OPERATION \_\_\_\_NO YES\_\_ explain \_\_\_\_\_

ALLERGIC TO MEDICATIONS \_\_\_\_NO YES\_\_ explain \_\_\_\_\_

ANY OTHER ALLERGIES \_\_\_\_NO YES\_\_ explain \_\_\_\_\_

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DO YOU HAVE A HISTORY OF:

- ANEMIA                       BONE DISORDERS                       EPILEPSY
- ASTHMA                         KIDNEY DISORDERS                       RHEUMATIC FEVER
- DIABETES                       LIVER INVOLVEMENT                       BLEEDING

PROBLEMS:

- HEART                       FAINTING OR DIZZINESS
- ENDOCRINE DISORDERS

EXPLAIN \_\_\_\_\_

**DENTAL HISTORY**

DENTIST \_\_\_\_\_ LAST EXAM \_\_\_\_\_

- THUMB/FINGER SUCKING    UNTIL AGE \_\_\_\_\_
- MOUTHBREATHING         AWAKE         ASLEEP
- GRINDING OR CLENCHING         DAY         NIGHT
- NAIL-BITING
- LIP BITING/LICKING
- BLEEDING GUMS
- INJURIES TO FACE/MOUTH/TEETH
- SORENESS OR CLICKING IN JOINT         NO         YES

HOW FREQUENTLY DO YOU USE FLOSS \_\_\_\_\_

HAVE YOU BEEN INFORMED OF ANY EXTRA OR MISSING TEETH? \_\_\_\_\_

ANY FURTHER COMMENTS: