

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/WorkPHONE _____
EMAIL _____

PARENT/GUARDIAN FULL NAME _____
HOME ADDRESS _____ TOWN _____ STATE _____ ZIP _____
OCCUPATION _____ EMPLOYED BY _____
HOME PHONE: _____ Cell/Work PHONE _____
EMAIL _____

PARENT/GUARDIAN FULL NAME _____
HOME ADDRESS _____ TOWN _____ STATE _____ ZIP _____
OCCUPATION _____ EMPLOYED BY _____
HOME PHONE: _____ Cell/Work PHONE _____
EMAIL _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

GENERAL APRAISAL

WHO CAN WE THANK FOR YOUR REFERRAL? _____

CHIEF COMPLAINT (REASON FOR CONSULTATION) _____

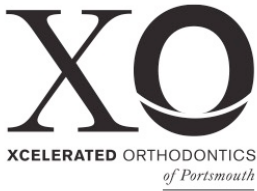
HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT? ___NO ___YES

IF YES, EXPLAIN _____

DOES PATIENT'S PROBLEM RESEMBLE ___FATHER ___MOTHER ___SIBLINGS

OTHER CHILDREN IN FAMILY	AGE	SEX	HAD ORTHO TREATMENT	NEEDS ORTHO TREATMENT
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____





MEDICAL HISTORY

PHYSICIAN/PEDIATRICIAN _____ 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 _____
ONSET OF PUBERTY
BOYS - HAS HIS VOICE CHANGED? ___ NO ___ YES WHEN _____
GIRLS - HAS MENSTRUATION BEGUN? ___ NO ___ YES WHEN _____

DOES PATIENT 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/PEDODONTIST _____ 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:

