



PATIENT INFORMATION

Patient's Name _____ Nickname _____

Birth Date ____/____/____ Age ____ Sex ____ School _____ Grade _____

Siblings names and ages (if applicable) _____

Father's Name (if applicable) _____

Mother's Name (or Spouse) _____

Whom may we thank for referring you to our office? _____

MEDICAL HISTORY

Is patient in good health? _____ Yes No

Has patient ever been under the care of a physician for a major illness? _____ Yes No

If so, circle which of the following the patient has been treated for :

- | | | | |
|------------------|-------------------------|----------------------|--------------|
| DIABETES | SPEECH PROBLEMS | PROLONGED BLEEDING | CANCER |
| PNEUMONIA | HEART DISEASE/MURMUR | FAINING OR DIZZINESS | ANEMIA |
| EPILEPSY | HIGH BLOOD PRESSURE | NERVOUS DISORDER | ASTHMA |
| RHEUMATIC FEVER | HEPATITIS/LIVER DISEASE | KIDNEY INVOLVEMENT | AIDS/HIV |
| BONE DISORDERS | EMOTIONAL PROBLEMS | ENDOCRINE PROBLEMS | HEADACHES |
| SLOW IN LEARNING | ENDOCRINE PROBLEMS | EYE OR EAR PROBLEMS | TUBERCULOSIS |

Have tonsils and adenoids been removed? What age? _____ Yes No

List any drugs or medications now being taken. Give reason: _____

List any drug allergies or drug sensitivities: _____

Has patient reached puberty? Girl – Started Menstruation? Yes No Height _____ Weight _____
 Boy – Voice Changed? Yes No Height _____ Weight _____

Doctor's signature _____ Update _____ Initial _____

DENTAL HISTORY

General Dentist _____ City _____ Last visit _____

Have there been any injuries or surgeries to the face, mouth, or teeth? _____ Yes No

Has the patient ever sucked a thumb or finger? Until what age? _____ Yes No

Does the patient have any speech problems? _____ Yes No

Have you been informed of any missing or extra permanent teeth? _____ Yes No

Has an orthodontist been consulted previously? _____ Yes No

Chief concerns? _____

Signature _____ Date _____

DATE	TREATMENT	EST. TX TIME