PATIENT HISTORY INFORMATION

Patient's Name_____Nickname_____Sex_____
Home Address_____Date of Birth_____

Information for patients who are minors:

FATHER	MOTHER
Name_____	Name_____
Address_____	Address_____
_____	_____
Business/Home Phone_____	Business/Home Phone_____
Cell Phone _____	Cell Phone_____
Email:_____	**Email**:_____

Parent's Marital Status**:** Married____ Separated____Divorced____Widowed____

Information for adult patients:

Occupation_____ Business Phone_____ Marital Status_____
Name of Spouse_____ Spouse's Business Phone_____
Children's Names and Ages _____

MEDICAL HISTORY

Is the patient experiencing any health problems? Yes____No____Reason_____
Any major or unusual illnesses? Yes____No____Explain_____
Currently under physician's care? Yes____No____Reason_____
Currently taking medication? Yes____No____List_____
Allergies? Yes____No____List_____
Drug sensitivity/allergies? Yes____No____List_____
Patient's Physician:_____ Physician's Phone:_____

Please Check if Patient Has or Had any of the Following:

_____ Heart Murmur **_____**Has the patient ever been advised to take antibiotics prior to dental treatment?

_____Anemia	_____Heart disease	_____Frequent colds or flu
_____Blood Disease	_____Tuberculosis	_____Mouth breathing
_____Prolonged bleeding	_____Endocrine Problems	_____Tonsillitis
_____Diabetes	_____Jaundice	_____Tonsils Removed:Age_____
_____Hepatitis	_____Bone Disorders	_____Adenoid or Sinus Infections
_____Rheumatic Fever	_____Asthma	_____Adenoids Removed:Age____
_____Herpes	_____Epilepsy/Seizure Disorder	_____AIDS/AIDS Related Complex

Is there any possibility that the patient could be pregnant?_____
Adolescent females only: Has the patient started having menstrual cycles?_____

DENTAL HISTORY

Name of local dentist patient sees for cavity checkups/restorative dentistry_____
What was the date of the patient's last dental cleaning?_____
Has the patient had any severe jaw or facial injuries?_____Explain_____
Has the patient had any injuries to teeth?_____Explain_____
Has the patient had a history of thumb or finger sucking?_____Explain_____
Has the patient consulted an orthodontist previously?_____
Are you satisfied with the prior treatment?_____

Has there ever been a history of:

____Clenching Teeth_____Muscular Soreness around head/neck_____Jaw Joint Soreness____Jaw Popping
____Grinding Teeth _____Excessive Headaches_____Jaw Joint Clicking_____Ringing in the ears

Is there any other information that may be helpful?_____
Why are you seeking an orthodontic consultation? (What problems require correction?)_____
_____
How did you hear about our office?_____

Signed_____Date_____