



Patient's Name \_\_\_\_\_  
First Middle Last

**PLEASE FILL OUT ALL THAT APPLY TO THE PATIENT**

General Dentist \_\_\_\_\_ When was your last visit with your dentist? \_\_\_\_\_

Current Dental Health  Good  Fair  Poor Any injuries to face, mouth, chin, teeth?  Yes  No

Tonsils and Adenoids removed?  Yes  No Extra or missing permanent teeth?  Yes  No

Tenderness in jaw or joint?  Yes  No Has patient ever been evaluated for orthodontic treatment before?  Yes  No

**DOES THE PATIENT HAVE ANY OF THE FOLLOWING HABITS**

\_\_\_\_\_ Clenching / Grinding Teeth \_\_\_\_\_ Lip Sucking / Biting \_\_\_\_\_ Mouth Breather \_\_\_\_\_ Nail Biting  
\_\_\_\_\_ Nursing Bottle Habits \_\_\_\_\_ Speech Problems \_\_\_\_\_ Thumb / Finger Sucking \_\_\_\_\_ Tongue Thrust

Main concerns \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

Current physical health?  Good  Fair  Poor

**PLEASE MARK ALL OF THE FOLLOWING MEDICAL PROBLEMS THAT APPLY TO THE PATIENT:**

- |                                    |                                      |  |
|------------------------------------|--------------------------------------|--|
| _____ Abnormal Bleeding            | _____ Anemia / Radiation Treatment   | _____ Artificial Bones / Joints / Valves |
| _____ Blood Transfusion            | _____ Cancer / Chemotherapy          | _____ Congenital Heart Defect            |
| _____ Diabetes / Tuberculosis (TB) | _____ Difficulty Breathing           | _____ Drug / Alcohol Abuse               |
| _____ Emphysema / Glaucoma         | _____ Epilepsy / Seizures / Fainting | _____ Fever Blisters / Herpes            |
| _____ Heart Attack / Stroke        | _____ Heart Murmur                   | _____ Heart Surgery / Pacemaker          |
| _____ Hemophilia                   | _____ Hepatitis                      | _____ High / Low Blood Pressure          |
| _____ HIV + / AIDS                 | _____ Hospitalized for any Reason    | _____ Kidney Problems                    |
| _____ Mitral Valve Prolapse        | _____ Psychiatric Problems           | _____ Rheumatic / Scarlet Fever          |
| _____ Severe / Frequent headaches  | _____ Shingles                       | _____ Sinus Problems                     |
| _____ Ulcers / Colitis             | _____ Venereal Disease               |  |

Please discuss any medical conditions: \_\_\_\_\_  
\_\_\_\_\_

Please list any allergies: \_\_\_\_\_ Please list all drugs patient is currently taking: \_\_\_\_\_  
\_\_\_\_\_

Has puberty begun?  Yes  No (For Women Only) Has menstruation begun?  Yes  No Approximate age \_\_\_\_\_

**EMERGENCY INFORMATION**

In case of Emergency, who may we call? Name \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Physician \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

**I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

Signature \_\_\_\_\_ Date \_\_\_\_\_