

What brought you to see us? Why are you here? _____

Referred By _____ Date _____

Patient's Name _____ Preferred Name _____

Birth date _____ Age _____ Sex _____ School _____ Grade _____

Patient's Dentist _____ Physician _____

Mother's Name _____ SSN _____

Home Address _____ Home Phone _____

Work Phone _____

Occupation _____ Employed By _____

Father's Name _____ SSN _____

Home Address _____ Home Phone _____

Work Phone _____

Email Address _____ Mobile Phone _____

Occupation _____ Employed By _____

Parent's Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Widow(er) _____

Name of any family members we have seen _____

Names and Ages of Other Children in the family _____

Person(s) responsible for Payment of Account _____

Address and Relationship to Patient _____

MEDICAL HISTORY

Is the patient in good health? _____ Does the patient have any history of major illness? _____

Please list (give dates) _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

HEART TROUBLE	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	ATTENTION DEFICIT	<input type="checkbox"/>	LIVER INVOLVMENT	<input type="checkbox"/>
MITRAL VALVE PRO	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	KIDNEY PROBLEMS	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>
HEART MURMUR	<input type="checkbox"/>	EPILEPSY	<input type="checkbox"/>	ENDOCRINE PROBLEMS	<input type="checkbox"/>	BLOOD DISORDERS	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	PROLONGED BLEEDING	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>
PNEUMONIA	<input type="checkbox"/>	FAINTING OR DIZZINESS	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>

Does patient have tendency to: Colds _____ Sore Throats _____ Ear Infections _____ Cold Sores _____

Have tonsils and adenoids been removed? _____ What Age? _____ List any drugs or medications now being taken and reason. _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

Has the patient reached puberty: Girls-has she started menstruation _____ If so date of onset _____

Boys-has his voice changed _____

DENTAL HISTORY

Date of last dental cleaning _____ Date of last X-rays _____

Has the patient had a Panoramic/Panorex X-ray? **Y / N / Don't know** If yes, When? _____

Have there been injuries to the face, mouth or teeth? **Y / N** If yes, describe and give date _____

Has the patient ever sucked a thumb or fingers? **Y / N** Age _____

Any pain in or near the ears? **Y / N** Does the patient have any speech problems? **Y / N**

Have you been informed of any missing or extra permanent teeth? **Y / N**

Has an orthodontist been consulted previously? **Y / N** Has either parent had orthodontic treatment? **Y / N**

List any musical instruments played _____

Interests or hobbies _____

Signature (parent or guardian's) _____