PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Last First Middle vddress:	Patient's name:					
Streted City 2p Sports/Hobbies:		Last	First		Middle	
Sports/Hobbies:	S				Zip	
Parent(s) or guardian(s) name:						
Whom may we thank for referring you to our office?: RESPONSIBLE PARTY INFORMATION Warne: Last First Middle tesidence: Street City Zp alalling Address: Street City Zp tome phone:	•					
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imail address:						
Birthdate:				-		
Employer: Occupation: No. years employed: Second Responsible Party's Name:	=mail address:					
Employer: Occupation: No. years employed: Second Responsible Party's Name:	Birthdate:	Relationshin to	Patient:			
Second Responsible Party's Name:		-			No. years employed:	
Relationship to Patient:						
Employer:	Second Responsible Party	/'s Name:				
authorize the following individuals to have complete access to patient records and accounts, and to make treatment tecisions: Signature: Date: DENTAL INSURANCE INFORMATION nsured's Name: Insured's Birth Date: Relationship to Patient: Group No.: ID# or SS#: Insurance Company: Insurance Co. City & State: No you have dual coverage? Yes Insured's Birth Date: Relationship to Patient: Stroup No.: Insurance Co. City & State: Do you have dual coverage? Yes Insured's Name: Insured's Birth Date: Relationship to Patient: State: Insured's Name: Insurance Co. City & State: Stroup No.: ID# or SS#: Insurance Company: Insurance Co. City & State: Stroup No.: ID# or SS#: Insurance Company: Insurance Co. City & State: Mame of nearest relative not living with you: Phone:	Relationship to Patient: Birthd		Birthdate:	Phone:		
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			EMERGENCY INFORMATI	ON		
	Name of nearest relative r	not living with you:		Phone:		

MEDICAL HISTORY

Physician:			Date of Last Visit:	_Date of Last Visit:					
Address:			Phone:						
Please circle Yes or No (If Yes, please fill in details)									
Yes	No	Is the patient taking any medication?	Is the patient taking any medication?Is the patient allergic to any medication?						
Yes	No	Is the patient allergic to any medication?							
Yes	No	History of a major illness?							
Yes	No	Has the patient had any operations?							
Yes	No	Has the patient had any operations?Ever been involved in a serious accident?							
Yes	No	Have seen a physician in the last 12 months? Why?							
		Female Patients only:							
Yes	No	Has menstruation started?							
Yes	No	Is the patient pregnant?	Is the patient pregnant?						
		e medical conditions below that the patient has had							
		ling/Hemophilia Diabetes	Hepatitis/Liver problems	Pneumonia					
Anemia		Dizziness	Herpes	Prolonged Bleeding					
Arthritis		Epilepsy	High Blood Pressure	Radiation/Chemotherapy					
	or Hayfe		HIV / Aids	Rheumatic Fever					
			Kidney problems	Tuberculosis					
		rt Defect Heart Murmur	Nervous Disorders	Tumor or Cancer					
Are the	re any m	nedical conditions we have not discussed that you fe	el we should be aware of? _						
		DENTAL HIS	STORY						
Genera	l Dentist:		Date of last visit:						
What is	the prim	: nary concern about the patient's teeth?:							
	· · F								
Yes	No	Is the patient presently in any dental pain?							
Yes	No	Ever experienced any unfavorable reaction to dentistry?							
Yes	No	Has the patient ever lost or chipped any teeth?							
Yes	No	Have there been any injuries to face, mouth, or teeth?							
Yes	No	Is any part of your mouth sensitive to temperature? Where?							
Yes	No	Is any part of your mouth sensitive to pressure? Where?							
Yes	No	Do gums bleed when brushing?							
Yes	No	Any type of thumb or tongue habit?							
Yes	No	Is the patient a mouth breather?							
Yes	No	Has the patient ever seen an orthodontist? If yes, who and when?							
Yes	No	What is the patient's attitude toward receiving orthodontic treatment?							
Yes	No Has anyone in the family received orthodontic treatment?								
	How did they feel about the result?								
Yes	No	Do teeth or jaws ever feel uncomfortable first thing in the morning?							
Yes	No	Experience jaw clicking or popping?							
Yes	No	Experience jaw clicking or popping?Aware of clenching or grinding teeth during the day?							
Yes	No	Experience "tension" headaches?							
Yes	No	Has the patient ever experienced chronic ringing in the ears?							
Yes	No	Does the patient need extra help with instructions?							
Yes	No	Is the patient sensitive or self-conscious about his	s/her teeth?						
Yes	No	Height of parents? Mom: Dad:Un	nkown:						
Yes	Yes No Are you aware that some appointments will be during school hours?								

CONSENT

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

Signature: ______Date: _____