Patient Medical History

Physician____________________

Approximate date of last physical exam____________________

Question	Yes	No
1. Are you under any medical treatment now____________	☐	☐
2. Have you had any medical operations? if so what?____________	☐	☐
3. Have you ever had a serious accident involving head injury? ____________	☐	☐
4. Have you had any allergic reactions to any drugs including penicillin? ____________	☐	☐
Has a Physician ever informed you that you had:		
5. A Heart Ailment?____________	☐	☐
6. High Blood Pressure? ____________	☐	☐
7. Respiratory Disease? ____________	☐	☐
8. Diabetes?____________	☐	☐
9. Rheumatic Fever? ____________	☐	☐
10. Rheumatism or Arthritis?____________	☐	☐
11. Tumors or Growths? ____________	☐	☐
12. Any Blood Diseases?____________	☐	☐
13. Any Liver Diseases? ____________	☐	☐
14. Any Kidney Diseases?____________	☐	☐
15. Any Stomach or Intestinal Diseases?____________	☐	☐
16. Any Venereal Diseases? ____________	☐	☐
17. HIV Positive? ____________	☐	☐
18. Yellow Jaundice or Hepatitis? ____________	☐	☐
19. Do you have night sweats accompanied by weight loss or cough?____________	☐	☐
20. Medications Taken Presently?____________	☐	☐
21. Are you allergic to any known materials resulting in hives, asthma, eczema?____________	☐	☐
22. Are you in general good health at this time____________	☐	☐
23. Have any wounds healed slowly or presented other complications?____________	☐	☐
24. Are you pregnant? ____________	☐	☐
25. Do you have a history of fainting? ____________	☐	☐
26. Are you on a diet at this time? ____________	☐	☐
27. Have you ever had any X-Ray treatments (other than diagnostic)? ____________	☐	☐

Patient Information For Minors

Patients Name____________Preferred First Name__________Sex: M F

Home Address____________________

Date of Birth__________ Age______Home Phone____________

Patients Dentist____________Referred By____________

Have any family members been a Patient Yes No Name____________

School Patient attends____________________Grade__________

Date of Last Dental Exam____________________

Any unusual Dental Experiences?____________________

How does Patient feel about orthodontics? Wants Undecided Does not want

Please complete the first column indicating who the patient lives with (the person responsible for the patients day to day activities, dental appointments, etc..) Indicate in the second column the person responsible for payment.

	Patient In Residence With	Financially Responsible Party
Name:	____________	____________
Relationship to Patient (mother, father, step parent, etc.)	____________	____________
Residential address	____________	____________
Length of time at address	____________	____________
Home Phone	____________	____________
Driver License #	____________	____________
Social Security Number	____________	____________
Birthdate(if insured)	____________	____________
Occupation	____________	____________
Employer's Name	____________	____________
Business Phone	____________	____________
Length of Employment	____________	____________

Marital Status: Single Married Separated Divorced Widowed Remarried

Persons other than those listed above that you wish to be informed of treatment or financial information: ____________________

Person to be notified in case of emergency:____________________

Are you covered by orthodontic insurance? Yes No

Name of Insured ____________Social Security Number__________

Name of Insurance Company____________ Phone__________

Group # ____________Policy # ____________

I understand that, where appropriate, credit bureau reports may be obtained

Signature ____________________ Date ____________