Patient Medical History

Physician_____

Approximate date of last physical exam_____

	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 _____