JOHN B. BENTON, JR., D.D.S.
Orthodontist

DATE ______________________ 20______

DATE OF BIRTH ______________________

PATIENT'S NAME ______________________
Last First Initial Age Sex

ADDRESS ______________________ ZIP __________ PHONE ______________________

DENTIST ______________________ PHYSICIAN __________ REFERRED BY __________

MARITAL STATUS — SINGLE _____ MARRIED _____ DIVORCED _____

EMPLOYED BY ______________________ OCCUPATION ______________________

SOCIAL SECURITY NO. ______________________ BUS. PHONE ______________________

SPOUSE'S NAME ______________________ S.S.# ______________________

EMPLOYED BY ______________________ OCCUPATION ______________________

BUS. ADDRESS ______________________ BUS. PHONE ______________________

MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH? ______________________ YES ☐ NO ☐

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? ______________________ YES ☐ NO ☐

HAS THE PATIENT EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR MAJOR ILLNESS? ______________________ YES ☐ NO ☐

PLEASE LIST: ______________________

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

DIABETES ☐	TUBERCULOSIS ☐	ENDOCRINE PROBLEMS ☐
PNEUMONIA ☐	ANEMIA ☐	PROLONGED BLEEDING ☐
HEART TROUBLE ☐	EPILEPSY ☐	FAINTING OR DIZZINESS ☐
RHEUMATIC FEVER ☐	ASTHMA ☐	NERVOUS DISORDERS ☐
BONE DISORDERS ☐	KIDNEY INVOLVEMENT ☐	LIVER INVOLVEMENT ☐

DOES PATIENT HAVE TENDENCY TO COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? ______________________ YES ☐ NO ☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS: ______________________

____

LIST ANY ALLERGIES OR DRUG SENSITIVITY: ______________________

HEIGHT __________ WEIGHT __________

DENTAL HISTORY

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? ______________________ YES ☐ NO ☐

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? ______________________ YES ☐ NO ☐

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? ______________________ YES ☐ NO ☐

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? ______________________ YES ☐ NO ☐

WHILE ASLEEP? ______________________ YES ☐ NO ☐

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? ______________________ YES ☐ NO ☐

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? ______________________ YES ☐ NO ☐

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? ______________________ YES ☐ NO ☐

____

REASON FOR CONSULTATION ______________________

____

EMERGENCY INFORMATION

Please give the names, addresses and phone numbers of 2 friends or relatives living closest to you.

1. ______________________
2. ______________________

ORTHODONTIC HISTORY

Has patient been seen by another orthodontist ________? If so, name and date ______________________

____

Was orthodontic treatment recommended ______ If so, was treatment undertaken ______________________

Signature ______________________
(of parent, if patient is a minor)