



DATE _____ 20____

DATE OF BIRTH _____

PATIENT'S NAME _____ Initial _____ AGE _____ SEX _____

RES. ADDRESS _____ Last _____ First _____ ZIP _____ TELEPHONE _____

SCHOOL _____ GRADE _____ REFERRED BY _____

PATIENT'S DENTIST _____ PHYSICIAN _____

FATHER'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ BUS. TELEPHONE _____

BUS. ADDRESS _____ SS NO. _____

MOTHER'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ BUS. TELEPHONE _____

BUS. ADDRESS _____

NAMES AND AGES OF OTHER CHILDREN IN FAMILY _____

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 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: _____

HAS THE PATIENT REACHED PUBERTY? GIRLS - HAS SHE STARTED MENSTRUATION YES NO
BOYS - HAS HIS VOICE CHANGED YES NO

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

LIST ANY MUSICAL INSTRUMENTS PLAYED: _____

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 _____

Is the patient under orthodontic treatment at present _____

Signature _____
(of parent if patient is a minor)