

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_  
Reason for this appointment? \_\_\_\_\_

### DENTAL HISTORY

(Please circle the appropriate answer)

Any previous orthodontic treatment? NO YES  
Any baby teeth or permanent teeth removed by a dentist? NO YES  
Any major falls or accidents involving the head, face or teeth? NO YES  
Any difficulty breathing through the nose (awake or asleep)? NO YES  
Any clenching of teeth or grinding teeth at night? NO YES  
Does anyone else in your family have similar dental problems? NO YES  
Dentist Name \_\_\_\_\_ Date teeth last cleaned \_\_\_\_\_

### HEALTH HISTORY

(Please circle if you have or had any of the following)

Tonsils and/or adenoids removed? NO YES Rheumatic fever? NO YES  
Heart Murmur? NO YES Diabetes? NO YES  
Drugs or other allergies? NO YES if yes, explain \_\_\_\_\_  
Environmental allergies (such as dogs, cats, trees, etc.)? NO YES  
if yes, explain \_\_\_\_\_  
Any Drugs or **NSAIDS** (Advil, Motrin) taken regularly? NO YES  
Any Osteoporosis medications? NO YES (ex Fosmax, Boniva) \_\_\_\_\_  
Any other health problems? NO YES if yes, explain \_\_\_\_\_  
Any behavior problems NO YES  
Have you ever tested positive for HIV or Hepatitis? NO YES  
Are you in good health now? NO YES  
Have you ever had a serious illness or injury? NO YES  
If yes, explain \_\_\_\_\_  
Please provide your Medical Doctor's name \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

### GENERAL INFORMATION

Residence address \_\_\_\_\_ Birthdate \_\_\_\_\_  
Home Address \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Email Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Position \_\_\_\_\_ Employer's Phone \_\_\_\_\_  
Do you have Dental Insurance? NO YES If yes, what provider? \_\_\_\_\_  
Orthodontic Coverage NO YES If yes, at what coverage? \_\_\_\_\_  
Does your spouse have dental insurance that provides coverage for you also NO YES  
Spouse Name \_\_\_\_\_ SSN \_\_\_\_\_  
Spouse Birthdate \_\_\_\_\_  
Are there special arrangements regarding billing of these procedures? \_\_\_\_\_

I understand that the information that I have given on the Dental and Medical history for and the information given to the Doctor are correct and complete to the best of my knowledge, and that it is my responsibility to inform the Doctor of any change in my child's medical or dental status.

Date \_\_\_\_\_ Signature \_\_\_\_\_