# PLEASE FILL OUT ALL INFORMATION ON THIS SHEET

Name ______________________ Date ______________________

Age ______________ Birth Date ______________ Sex ______________

Responsible Person (if patient is under 18) ______________________

Home Address ______________________

Business Telephone ______________ Home Telephone ______________

Whom may we thank for sending you to this office? ______________________

Family Dentist ______________ Address ______________

Family Physician ______________ Address ______________

School ______________________ Grade ______________

Orthodontic Insurance Company ______________________

Insured's Birthdate ______________ Insured's Social Security # ______________

Place of Employment ______________ Responsible Party #1 ______________ Party #2 ______________

Email Address ______________________

## HISTORY

Chief Complaint ______________________

Present State of Health ______________________

Height ______________ Weight ______________

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Were there any unusual circumstances connected with any childhood diseases? ______________ |
| ☐ | ☐ | Are you now or have you ever been under a physician's care? |
| ☐ | ☐ | Have you been hospitalized? For what? ______________ |
| ☐ | ☐ | Allergies: ☐Food ______________ ☐Pollen ______________ ☐Drugs ______________ |
| ☐ | ☐ | Major Medical Disorders: heart, kidneys, lungs, liver, blood disorders, diabetes, epilepsy, rheumatic fever? |
| ☐ | ☐ | Tonsils and adenoids removed? |
| ☐ | ☐ | Habits: tongue, lip, thumb, finger, nail biting, bobby pins, pencils, grinding, mouth breathing? |
| ☐ | ☐ | Does the patient desire treatment? |
| ☐ | ☐ | Do you have difficulty chewing? What foods? ______________ |
| ☐ | ☐ | Do you or have you ever worn a dental appliance? |

Additional Information ______________________

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