## General Information

Patient Name:

List Interests and activities:

List other family members who have had treatment in this office:

Why are you seeking orthodontic treatment?

Has the patient ever been evaluated for or had orthodontic treatment before?

| Dentist's name: | Phone number: |
|---|---|

## Medical History

| Physician's name: | Phone number: |
|---|---|
| | |

Current Medications:

Describe any major accidents, surgeries, etc:

**Have you ever been diagnosed with any of the following?**
**Please mark either yes or no.**

| | Yes(Y) | No(N) | | Yes(Y) | No(N) |
|---|---|---|---|---|---|
| Aids/HIV Positive | | | Abnormal Bleeding | | |
| Allergies, Latex/Metal/Other | | | Blood transfusions | | |
| Breathing Problems | | | Congenital Heart Defects | | |
| Snoring | | | Diabetes | | |
| Daytime tiredness | | | Hepatitis | | |
| Convulsions | | | Pregnant (currently) | | |
| Dizziness/Fainting | | | Repeated headaches | | |
| Herpes(fever Blisters) | | | TMJ(Jaw joint) problems | | |
| Rheumatic Fever | | | Tonsils/Adenoids removed | | |
| Tuberculosis | | | Recent head/neck trauma | | |
| | | | | | |
| Have Wisdom teeth been removed | | | Is pre-medication necessary? | | |
| If removed, when? | | | If yes, what medication? | | |
| | | | | | |
| Has the patient been informed of any missing or extra teeth? | | | | | |

**Do you have any of the following Habits?**

| | | | | | |
|---|---|---|---|---|---|
| Clenching/grinding teeth | | | Speech Problems | | |
| Thumb/Finger sucking | | | Mouth Breather | | |

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my (my child's) medical status.

_____ _____

Signature of parent or guardian Date