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Patient Name: _____ D.O.B._____
Who may we thank for recommending us:_____

Name of Dentist: _____ Date of last visit: _____

MEDICAL HISTORY

Please check if patient has or has had

Y	N		Y	N		Y	N	
{ }	{ }	Joint swelling	{ }	{ }	Brain Injury	{ }	{ }	Tonsils Removed
{ }	{ }	Bone disorders	{ }	{ }	Kidney or liver disease	{ }	{ }	Adenoids removed
{ }	{ }	Heart trouble	{ }	{ }	Joint Replacement	{ }	{ }	Sore throats
{ }	{ }	Mitral Valve Prolapse	{ }	{ }	Tuberculosis	{ }	{ }	Tonsillitis
{ }	{ }	Rheumatic Fever	{ }	{ }	Anemia	{ }	{ }	Earaches
{ }	{ }	Thyroid problems	{ }	{ }	Epilepsy(convulsions)	{ }	{ }	Arthritis
{ }	{ }	Diabetes	{ }	{ }	Prolonged bleeding			
{ }	{ }	Emotional Problems	{ }	{ }	Faintness/Dizziness			

On items checked "Yes" please provide us with a more detailed description:_____
_____
Approximately how much has patient grown in the last year?_____

What would you like to have orthodontic treatment accomplish?_____
_____

List any other serious illness:_____

List any allergies:_____

List drugs or medications now being taken:_____

Do you currently or have you taken bisphosphonate drugs:_____ Explain:_____
_____

Is patient presently under physicians care?_____Reason:_____

Name of Primary Physician:_____ Other:_____
_

DENTAL HISTORY

Please check yes or no

Y	N		Y	N	
{ }	{ }	Any injuries to face, mouth, teeth? (circle)	{ }	{ }	Any teeth removed by extraction?
{ }	{ }	Thumb, finger, lip, sucking? (circle)	{ }	{ }	Any difficulty in swallowing or chewing?
{ }	{ }	More than average amount of decay?	{ }	{ }	Any pain or clicking on opening mouth?
{ }	{ }	Any missing permanent teeth?	{ }	{ }	Is patient adopted? At what age? _____
{ }	{ }	Any extra permanent teeth?	{ }	{ }	Does patient visit dentist regularly?
{ }	{ }	Has an orthodontist been consulted previously? If yes list reason:_____			

_____

Patient's attitude to orthodontic treatment:
Circle one Very motivated Will cooperate if needed Not motivated

_____ _____
Date Signature of patient or parent or guardian if patient is a minor