



1st Visit Date _____ PATIENT NAME: _____
LAST FIRST M.I.

Male ___ Female ___ Unspecified ___ Age _____ Date of Birth _____ SS# _____

Home Address _____ City _____ Zip _____

Home Phone # _____ Cell Phone # _____ Email Address _____

Occupation _____ Employer _____

Business Address _____ Business Phone _____

Referred by _____ Patient's Dentist _____ Last visit _____

Patient's Physician _____ Oral Surgeon _____

Spouse's Name _____ SS# _____

Occupation _____ Employer _____

Business Address _____ Business Phone _____

HEALTH HISTORY: Are you in good health? YES ___ NO ___ If no, please explain:

Do you have a history of major illness or injury? YES ___ NO ___ If yes, please describe:

Have you ever been treated for: Rheumatic Fever Hepatitis HIV Heart Problem Glaucoma

LIST ANY CURRENT DRUGS/MEDICATIONS: _____

LIST ANY DRUG ALLERGIES OR SENSITIVITIES: _____

Have your tonsils or adenoids been removed? YES ___ NO ___ If so, when? _____

Names & Ages of Children _____

HAVE YOU HAD ANY INJURIES TO YOUR FACE, MOUTH, OR TEETH? YES ___ NO ___ If yes, please explain:

Do you normally breathe through your (While awake): _____ Mouth or _____ Nose?
(While asleep): _____ Mouth or _____ Nose?

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA TEETH? _____

Do you have any history of gum disease? _____ Clicking, popping or jaw pain? _____

Have you previously consulted with an Orthodontist? _____

PRIMARY REASON FOR CONSULTATION _____

Has any member of your family ever been seen in this office? If yes, who? _____

Date _____ Signature _____