PATIENT'S NAME _____ DATE OF BIRTH _____ PHONE _____

HOME ADDRESS _____ CITY _____ ZIP _____

SCHOOL _____ GRADE _____ AGE _____ M F DATE _____

FATHER'S NAME _____ OCCUPATION _____

IF MILITARY RANK _____ UNIT _____ SSN _____

HOME ADDRESS _____ CITY _____ ZIP _____

EMPLOYED BY _____ WORK PHONE _____

MOTHER'S NAME _____ OCCUPATION _____

HOME ADDRESS _____ CITY _____ ZIP _____

EMPLOYED BY _____ SSN _____ WORK PHONE _____

PERSON RESPONSIBLE FOR ACCOUNT _____ INS. _____

PATIENT'S DENTIST _____ PHYSICIAN _____ REFERRED BY _____

DENTAL HISTORY

	YES	NO
Has the patient ever sucked thumb or fingers?	☐	☐
Does the patient breathe predominantly through the mouth?	☐	☐
Have you been informed of any missing permanent teeth?	☐	☐
Have you been informed of any extra teeth?	☐	☐
Have any teeth been injured due to accidents or falls?	☐	☐
Has the patient had any severe head or facial injuries?	☐	☐
Is the patient especially apprehensive toward dental visits?	☐	☐
Any jaw clicking or popping?	☐	☐

LIST ANY DRUGS OR MEDICATION NOW BEING TAKEN:

MEDICAL HISTORY

Check any of the following for which the patient has been treated:

Diabetes	☐	Hepatitis	☐
Rheumatic Fever	☐	Emotional Problems	☐
Heart Trouble	☐	Kidney Problems	☐
HIV+ / Aids	☐	Eye Problems	☐
Epilepsy	☐	Allergies to Drugs	☐
Asthma	☐	Wear Contact Lenses	☐
Hay Fever / Allergies	☐	Other Serious Illness	☐
Abnormal Bleeding	☐	Any Operations	☐
Fainting or Dizziness	☐	Any Stays in a Hospital	☐
Tuberculosis	☐		