MEDICAL-DENTAL HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION:

Patient Name: _____ Today's Date: _____

Patient's Height _____ Patient's Weight _____ Patient's Birth Weight _____

1. Have you been under the care of a physician during the past two years? Yes No

   If yes, for what? _____

2. Are you taking any medication, drugs or pills now? Yes No

   If yes, please list name and dosage _____

3. Are you aware of having an allergic (or advere reaction) to any medication or substance? Yes No

   If yes, please list _____

   Other allergies? List _____

4. Indicate which of the following you have had, or have at present. Circle yes or no to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Chest Pain	Yes	No
Congenital Heart Disease	Yes	No	Heart Murmur	Yes	No
Shortness of Breath	Yes	No	High Blood Pressure	Yes	No
Mitral Valve Prolapse	Yes	No	Artificial Heart Valve	Yes	No
Rheumatic Fever	Yes	No	Arthritis/Rheumatism	Yes	No
Kidney Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Ulcers	Yes	No	Diabetes	Yes	No
Thyroid Problems	Yes	No	Glaucoma	Yes	No
Tuberculosis	Yes	No	Asthma	Yes	No
Hay Fever	Yes	No	Allergy or Hives	Yes	No
Sinus Trouble	Yes	No	Tumors	Yes	No
Yellow Jaundice	Yes	No	Hepatitis A/B	Yes	No
Venereal Disease	Yes	No	H.I.V.	Yes	No
Cold Sores/Blisters	Yes	No	Sickle Cell Disease	Yes	No
Hemophilia	Yes	No	Anemia	Yes	No
Liver Disease	Yes	No	Tonsilitis	Yes	No
Ear or Hearing Problems	Yes	No	Emotional Problems	Yes	No

5. Do you have or have you had any disease, condition, or problem not listed? Yes No

   If yes, please list _____

6. Have you ever been required to premedicate with antibiotics prior to a dental visit? Yes No

7. Female: Age of first Menstruation _____ Age of onset of mother's Menstruation _____

8. Are there any problems, handicaps or restrictions that may have a bearing on successful orthodontic treatment? Yes No

   If yes, please list _____

OVER

9. Reason for seeking orthodontic treatment _____

_____

10. Has any other family member received orthodontic treatment? _____

11. Was the patient adopted? Yes No

12. History of:

Injury to Face and Head?	Yes	No	Comments: _____
Tooth Injury?	Yes	No	Chipped _____ Broken _____ Lost _____
Oral Disease (Infections)?	Yes	No	Gums _____ Ulcers _____ Sores _____
Jaw Joint Pain?	Yes	No	Right side _____ Constant _____ Periodic _____
			Left side _____ Constant _____ Periodic _____
			Comments: _____
Jaw Joint Noises?	Yes	No	Right side _____ Constant _____ Periodic _____
			Left side _____ Constant _____ Periodic _____
			Comments: _____
Grinding Your Teeth?	Yes	No	During the day _____ When sleeping _____
Clenching Your Teeth?	Yes	No	During the day _____ When sleeping _____
Bleeding Gums?	Yes	No	Usually _____ Sometimes _____ Rarely _____
		When:	Brushing _____ Flossing _____ Eating _____
Oral Habits	Yes	No	Thumb Sucking Finger Sucking
			Tongue Thrusting Nail Biting
Other Oral Problems	Yes	No	If yes, please explain: _____
			_____
Tonsils, Adenoids	In	Out	
Mouth Breathing	Yes	No	When: Day _____ Night _____
Speech Problem?	Yes	No	
Speech Therapy?	Yes	No	

13. Are there any current dental problems under treatment or not being treated? _____

_____

I understand the above information is necessary to provide me with orthodontic care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, for this required information. I will notify the doctor of any changes in my health or medication.

Signature _____ Date _____

PATIENT REGISTRATION ADULT

(Please Print)

PATIENT'S LAST NAME	First	Middle Initial	AGE	DATE OF BIRTH Month	Day	Year

PATIENT'S ADDRESS Street	City	Zip Code	HOME PHONE #

E-MAIL ADDRESS	CELL PHONE #

OCCUPATION	EMPLOYER NAME	WORK PHONE #

EMPLOYER'S ADDRESS	SOCIAL SECURITY #

SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	EMPLOYER'S NAME AND ADDRESS

SPOUSE'S SOCIAL SECURITY #	WORK PHONE #	RESPONSIBLE PARTY

NAME OF PATIENT'S DENTIST	ADDRESS	PHONE #

PATIENT'S DENTAL INSURANCE CO. - Name, Address, Phone	ID #	GROUP #

SPOUSE'S DENTAL INSURANCE - Name, Address, Phone	ID #	GROUP #

REFERRED BY

FINANCIAL RESPONSIBILITY

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 30%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due.

Signature _____ Date _____

PATIENT REGISTRATION YOUTH

(Please Print) PATIENT'S BIRTHDATE

PATIENT'S LAST NAME First Middle Initial	AGE (yrs & mos)	Sex	Month	Day	Year

PATIENT'S ADDRESS Street City Zip Code	NICKNAME

HOME PHONE #	MOTHER'S CELL #	FATHER'S CELL #	EMAIL ADDRESS

FATHER'S NAME	OCCUPATION	EMPLOYER'S NAME AND ADDRESS	WORK PHONE #

MOTHER'S NAME	OCCUPATION	EMPLOYER'S NAME AND ADDRESS	WORK PHONE #

FATHER'S SOC. SEC. #	FATHER'S BIRTHDATE	FATHER'S DENTAL INSURANCE CO.- Name, Address, Phone Subscriber's ID #	ORTHO COVERAGE YES NO

MOTHER'S SOC. SEC. #	MOTHER'S BIRTHDATE	MOTHER'S DENTAL INSURANCE CO.-Name, Address, Phone Subscriber's ID #	ORTHO COVERAGE YES NO

PARENT'S MARITAL STATUS	FATHER'S / MOTHER'S ADDRESS (if different)	HOME PHONE #

RESPONSIBLE PARTY

PATIENT'S DENTIST	ADDRESS	PHONE #

REFERRED BY	AGES OF BROTHERS AND SISTERS

FINANCIAL RESPONSIBILITY

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Signature _____ Date _____