

Date: _____

PATIENT INFORMATION/MINOR

Sex: M _____ F _____

Patient's Name: _____

First

Middle

Last

Address: _____ City & Zip: _____

Phone #: _____ Patient's Email Add: _____ Date of Birth: _____ Age: _____

Referred By: _____ Patient's Dentist: _____

Father's Name: _____ SS#: _____

Home Address: _____ City & Zip: _____

Employer: _____ Occupation: _____ Phone: _____

Mother's Name: _____ SS#: _____

Home Address: _____ City & Zip: _____

Employer: _____ Occupation: _____ Phone: _____

Person Responsible for this Account: _____

Responsible Party's Email Address: _____

Do you have Orthodontic Insurance? _____ Through what company? _____

Current Rx Medications: _____ Drug Allergies: _____

Other Family Members in Treatment: _____

DISEASE HISTORY:

A. Cardiovascular and Related Heart Diseases	Yes	No	E. Other Diseases	Yes	No
1. Rheumatic Heart Disease	___	___	1. Arthritis	___	___
2. Rheumatic Fever	___	___	2. Inflammatory Rheumatism	___	___
3. Congenital Heart Disease or lesions	___	___	3. Kidney Problems	___	___
4. Subacute Bacterial Endocarditis	___	___	4. Diabetes	___	___
5. Heart Murmur	___	___	5. Hypoglycemia	___	___
6. Heart Attack or Trouble	___	___	6. Liver Disease or Jaundice	___	___
7. Mitral Valve Prolapse	___	___	7. Cancer	___	___
8. Arteriosclerosis	___	___	8. Scarlet Fever	___	___
9. Angina Pectoris or Coronary Insufficiency	___	___	9. Eating Disorders	___	___
10. Low Blood Pressure	___	___	10. Other _____	___	___
11. Stroke	___	___			
B. Allergic Diathesis			F. Infectious Diseases		
1. Allergy of any type	___	___	1. Hepatitis	___	___
2. Hay Fever	___	___	2. Tuberculosis	___	___
3. Hives or Skin Rash	___	___	3. Venereal Disease	___	___
4. Nickel	___	___	4. Syphilis	___	___
C. Respiratory Diseases			5. Herpes	___	___
1. Asthma	___	___	6. Gonorrhea	___	___
2. Emphysema	___	___	7. HIV/AIDS	___	___
3. Sinus Trouble	___	___			
4. Tuberculosis	___	___			
D. Nervous System Disorders					
1. Fainting	___	___			
2. Convulsions	___	___			
3. Epilepsy	___	___			
4. Ulcers	___	___			
5. Other _____	___	___			

Have you been exposed to any infectious disease in the past 6 months? _____ Yes _____ No

Name of any physicians that you are seeing: _____

Emergency contact name: _____ Phone #: _____

Parent/Guardian Signature: _____