WELCOME TO OUR OFFICE

PREFERRED NAME	D.O.B	GENDER	PT. PHONE

COMPUTER NO. | LAST | PATIENT NAME | MODEL NO. | EXAM DATE

PT. ADDRESS
STREET | CITY | PROV. | P.C.

IF STUDENT, SCHOOL NAME | HOBBIES & INTERESTS

PARENT | PARENT
IF PATIENT IS A MINOR - PARENT'S/GUARDIAN NAME | WHO REFERRED PT.

FAMILY DENTIST | ADDRESS

PHYSICIAN | ADRESS

PERSON(S) RESPONSIBLE FOR ACCOUNT	PERSON(S) RESPONSIBLE FOR ACCOUNT
(LAST) (FIRST) (MIDDLE)	(LAST) (FIRST) (MIDDLE)
STREET CITY PROV. P.C.	STREET CITY PROV. P.C.
HOME PHONE | WORK PHONE | BIRTHDATE | RELATIONSHIP TO PT.	HOME PHONE | WORK PHONE | BIRTHDATE | RELATIONSHIP TO PT.
EMPLOYER'S NAME	EMPLOYER'S NAME
STREET CITY PROV. P.C.	STREET CITY PROV. P.C.
ORTHODONTIC INS. CO. NAME EMAIL:	ORTHODONTIC INS. CO. NAME EMAIL:

	YES	NO	
Is the patient in good health?	☐	☐	Reason ___
Any major or unusual illnesses?	☐	☐	Explain ___
Currently under physicians care?	☐	☐	Reason ___
Currently taking medicaton	☐	☐	List ___
Allergies	☐	☐	List ___
Drug sensitivity	☐	☐	List ___
Have you ever been hospitalized?	☐	☐	If so, for what? ___

Please check (✓) if patient has or has had any of the following:

	YES	NO
Anaemia	☐	☐
Blood disease	☐	☐
Prolonged bleeding	☐	☐
Hepatitis	☐	☐
Jaundice	☐	☐
Heart disease	☐	☐
Tuberculosis	☐	☐
Diabetes	☐	☐
Endocrine problems	☐	☐
Bone disorders	☐	☐
Epilepsy	☐	☐
Herpes	☐	☐
Rheumatic fever	☐	☐
Do you reuire prophyliactic medication?	☐	☐
Do you have AIDS or are you HIV positive?	☐	☐
Frequent colds or flu	☐	☐
Tonsilitis	☐	☐
Adenitis	☐	☐
Tonsils removed: Age:	☐	☐
Adenoids removed: Age:	☐	☐
Asthma	☐	☐
Mouth breathing: While awake?	☐	☐
While asleep?	☐	☐
Heart problems	☐	☐
Congenital heart defects	☐	☐
Heart murmur	☐	☐
Prosthetic joints	☐	☐
Joint pain	☐	☐
Arthritis	☐	☐
Frequent headaches	☐	☐

Growth information for patients under 16 years of age
Father's height ___ Mother's height ___ Are you adopted? ☐ Yes ☐ No
Patient resembles ☐ Father ☐ Mother ☐ Neither Parent
Girls: Has she started menstruation? ☐ Yes ☐ No When? ___
Boys: Has his voice changed? ☐ Yes ☐ No When? ___
Name and ages of patient's brothers and sisters ___

	YES	NO
Has the patient had trauma to the teeth?	☐	☐
Has the patient had any severe head or face injuries?	☐	☐
Has the patient had a history of thumb sucking or finger sucking?	☐	☐
Does the patient play any musical (wind) instruments?	☐	☐
Has the patient consulted an orthodontist previously?	☐	☐
Has the patient had any previous orthodontic treatment?	☐	☐
Has the patient ever had a bad dental experience?	☐	☐
Is the patient fearful of having dental work done?	☐	☐

Reason ___
Explain ___
Stopped? ___
What? ___
___
___
Explain ___
___

Please check (✓) if there is a history of:

	YES	NO
Clenching teeth	☐	☐
Grinding teeth	☐	☐
Muscular soreness around the head and neck	☐	☐
Headaches (more than normal)	☐	☐
Jaw joint soreness	☐	☐
Jaw joint clicking	☐	☐
Jaw joint popping	☐	☐
Ringing in the ears	☐	☐
Jaw joint locking	☐	☐

☐ Open ☐ Closed

Is there any other information that may be helpful? ___
Why are you seeking orthodontic consultation? ___

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to this history records, I will inform this practice. I also give my authorization for an orthodontic axam to be performed.

THANK YOU! Signed ___