WELCOME!

Name ____ Date ________________
(Last) (First) (Called by)

Address ____
(Street address) (City) (State) (Zip code)

Home # ________________ Cell #________________ Work # ________________ Email _____________________

Date of birth ____________ Age _________________ Height _________________ Weight ____________________

Work Address ____
(Street address) (City) (State) (Zip code)

Dentist _______________________________________ Physician _______________________________________

Referred by _____________________________________ Social Security # __________________________________

Person responsible for this account __________________________________ Relationship _________________________

Employer ____ Work Phone _________________________

Home address (if different from above) ____
(Street address) (City) (State) (Zip code)

Home # ________________ Cell #________________ Email ________________________________

Have you ever had any of the following medical problems? Please circle response and comment below.

Y	N	Rheumatic Fever	Y	N	Allergy to latex/metal/drugs/food
Y	N	Diabetes	Y	N	Eating disorder
Y	N	Epilepsy/Seizures	Y	N	Mental/Behavior Problems
Y	N	Tuberculosis (TB)	Y	N	Operations/Hospitalization
Y	N	Congenital Heart Defect/Heart Murmur	Y	N	Handicaps/Disabilities
Y	N	Sinus Problems	Y	N	Asthma
Y	N	Cancer	Y	N	Recurrent tonsillitis/Tubes in ears
Y	N	Hemophilia/Bleeding Disorder	Y	N	Tonsils or Adenoids Removed
Y	N	Hepatitis	Y	N	Injuries to face, mouth, teeth, chin
Y	N	HIV +/AIDS	Y	N	Any missing/extra/impacted teeth
Y	N	Attention Deficit Disorder/ADHD	Y	N	Females: Are you pregnant?
Y	N	Substance Abuse/Addiction			

Y N Females: Are you now taking, or have you taken in the past 10 years, medications known as "bisphosphonates." For example: **Fosamax** (alendronate), **Actonel** (risedronate), **Boniva** (ibandronate), **Skelid** (tiludronate), **Didronel** (etidronate), **Aredia** (pamidronate) or **Zometa** (zoledronic acid)

Please discuss any medical problems you have: ____
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Please list any medications you are currently taking: ____
Have you ever been examined or treated by another orthodontist? _________________________ When and by whom?_______________

Do you have any of the following:

Y	N	Speech Problems	Y	N	Thumb/Finger Sucking (previous/now)
Y	N	Snoring	Y	N	Special blanket/pillow/stuffed animal
Y	N	Clenching/grinding teeth	Y	N	Tongue Thrust
Y	N	Mouth breathing	Y	N	Pain/tenderness in jaw (TMJ)/headaches

What do you think is wrong with your teeth? ____
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Patient Signature