CHILD

Date:________________________ Child's Name:______________________________________ Age: ________

Date of Birth: _________________ Gender: _____ School: _____________________________ Grade: _______

Dentist: ____ Referred By: ____

Name of Parents or Guardian: ____ Relationship to child: _________________________

Address: ____ Email: _____________________________________

City: _______________________________ State: ________ ZIP: _______________ Home Phone: _______________________

FATHER

Name: ____ Social Security #: ___________________________________

Driver's Lic #: ____________________________ Email: _____________________________ Cell Phone: __________________

Employed By: ____________________________ Occupation: _________________________ Work Phone: __________________

Work Address: __________________________________ City: ________________________ State ______ ZIP___________

MOTHER

Name: ____ Social Security #: ___________________________________

Driver's Lic #: ____________________________ Email: _____________________________ Cell Phone: __________________

Employed By: ____________________________ Occupation: _________________________ Work Phone: __________________

Work Address: __________________________________ City: ________________________ State ______ ZIP___________

Do you have Orthodontic Insurance? ___ Yes ___ No If so, Company Name: ____

Address: ____ Group #: ____

City: ______________________________________ State: _______ ZIP: _______________ Phone: _______________________

MEDICAL HISTORY

Physician's Name & Address: ____

Date of last physical exam: _______________________________ Height: ____________ Weight: ________________

Have you or are you now under a physician's care for a health care problem? ___ Yes ___ No

If so, for what? ____

Have you been hospitalized in the last 5 years? ___ Yes ___ No If so, for what? _____________________________________

What medicines are you currently taking? ____

What operations have you had in the past? ____

Any known prescription drug allergies? ____

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD

__ Allergies to penicillin
__ Allergies to local anesthesia
__ Allergies to food or drugs
__ Anemia
__ Fatigue easily
__ Prolonged bleeding from surgery
__ Heart problems
__ Chest pain
__ Swelling of ankles
__ Heart murmur
__ Stroke
__ High blood pressure
__ Low blood pressure
__ Lung disease
__ Asthma
__ Shortness of breath
__ Tuberculosis
__ Bloody cough
__ Headaches
__ Fainting or dizziness
__ Epilepsy
__ Sinus Problems
__ Neck pain or swelling
__ Difficulty swallowing
__ Thyroid problems
__ Visual problems (glasses?)
__ Frequent illness or infections
__ Tumors or growths
__ X-ray or cobalt therapy
__ Slow healing
__ Severe weight loss
__ Diabetes (sugar in blood)
__ Hepatitis (yellow jaundice)
__ Ulcers
__ Kidney problems
__ Steroid therapy (cortisone)
__ Drug dependence
__ Psychiatric care
__ Women: Are you pregnant?
__ Other physical condition