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PATIENT INFORMATION: MINOR (Up tp 18 years of age)

Date: _____

Name: _____ Birthdate: _____
Last First Middle initial

I prefer to be called: _____ Gender (circle one): Male Female Other: _____

Home Address: _____
street city zip code

Home Phone: ( ) _____ Cell: ( ) _____ Email: _____

School Attending: _____

Father's Name: _____ Birthdate: _____

SSN: _____-_____-_____ Driver's Lic. # or Ca. ID #: _____

Employer: _____ Occupation: _____ Work #: ( )_____

Work Address: _____

Mother's Name: _____ Birthdate: _____

SSN: _____-_____-_____ Driver's Lic. # or Ca. ID #: _____

Employer: _____ Occupation: _____ Work #: ( )_____

Work Address: _____

In case of emergency, please contact:

Name: _____ Phone #: ( )_____ Relationship to Patient: _____

Name of Physician: _____ Phone #: ( )_____

***Whom may we thank for referring you*?** _____

Insurance Information (please fill all that apply)

Primary:	Secondary:
Subscriber's name: _____	Subscriber's name: _____
Relationship to pt.: _____	Relationship to Pt.: _____
D.O.B.: _____/_____/_____	D.O.B.: _____/_____/_____
SSN: _____-_____-_____	SSN: _____-_____-_____
Insurance Company:_____	Insurance Company: _____
Insurance Address: _____	Insurance Address: _____
_____	_____
Insurance Policy #: _____	Insurance Policy #: _____

DENTAL HISTORY

1. Do you have any concerns about your teeth and/or gums? _____
2. Have you had any previous orthodontic treatment? Please describe:_____
3. When was your last dental treatment?: _____
4. Have you had any unfavorable reaction from any previous dental treatment? YES NO
5. Have you ever had a local anesthetic? YES NO

HEALTH QUESTIONAIRE

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please Circle YES or NO where applicable

MEDICAL HISTORY

1. Are you in under a physician's care now? ..... YES NO
   If yes, please explain _____
2. Have you ever been hospitalized? ..... YES NO
3. Are you allergic to any of the following? (Please circle)

   ASPIRIN PENICILLIN CODEINE SULFA DRUGS LATEX OTHER _____

4. Do you use tobacco and/or controlled substances? YES NO If yes: _____
5. Do you have or have you had any of the following?:

AIDS/HIV Positive	YES	NO	Hepatitis (A, B, or C)	YES	NO
Anemia	YES	NO	High Blood Pressure	YES	NO
Arthritis/Gout	YES	NO	High Cholesterol	YES	NO
Asthma	YES	NO	Kidney Problems	YES	NO
Bruise Easily	YES	NO	Low Blood Pressure	YES	NO
Cancer	YES	NO	Lung Disease	YES	NO
Cortisone Medicine	YES	NO	Osteoporosis	YES	NO
Diabetes	YES	NO	Psychiatric Care	YES	NO
Epilepsy or Seizures	YES	NO	Sinus Trouble	YES	NO
Excessive Bleeding	YES	NO	Stomach/Intestinal Disease	YES	NO
Hay Fever	YES	NO	Stroke	YES	NO
Heart Attack/Failure	YES	NO	Tuberculosis (Active).....	YES	NO
Heart Pacemaker	YES	NO	Ulcers	YES	NO
Heart Trouble/Disease	YES	NO	Venereal Disease	YES	NO

6. Do you have any disease, condition, or problem not listed above that we should know about? YES NO
   If yes, please describe: _____
7. List any medications you are currently taking: _____
   (or use a separate sheet if necessary) _____
8. Any use of Medications such as: Fosamax (Biophosphonate) or Plavix? ..... YES NO
   When Started: _____ When Stopped: _____
9. Women only: Are you pregnant or trying to get pregnant? ..... YES NO

To the best of my knowledge, all of the above information is true and correct. If there is any change in my health condition or medication, it is my responsibility to inform the doctor at my next dental appointment.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ Date: _____ Reviewed by: _____

Re-care updates:

Date: _____/_____/_____ Patient Initials: _____ Reviewed by: _____
Date: _____/_____/_____ Patient Initials: _____ Reviewed by: _____
Date: _____/_____/_____ Patient Initials: _____ Reviewed by: _____
Date: _____/_____/_____ Patient Initials: _____ Reviewed by: _____
Date: _____/_____/_____ Patient Initials: _____ Reviewed by: _____