



Patient Name _____ Sex: M F
Last First Middle

Name Patient Prefers to be called _____ Date of Birth _____

Address _____ Home Phone _____
Street City Zip

School _____ Grade _____ Last Visit to Dentist _____

Patient's Dentist _____ Physician _____

Whom may we thank for referring you to us? _____

Do you plan to relocate out of the area in the near future? _____ If so, when? _____

Which office location is most convenient for you? Pensacola Pace Jay

Father's Name _____ Social Security No. _____

Employer _____ Business Phone _____

Other Phone Number(s) Father can be reached at _____

Mother's Name _____ Social Security No. _____

Employer _____ Business Phone _____

Other Phone Number(s) Mother can be reached at _____

Is the Patient under any medical treatment now? YES NO If so, what? _____

List any medications your child is currently taking _____

List any drug allergies/sensitivities _____

Is there a history of serious illness, accident, surgery, or other condition? _____

Has the Patient had any injury/trauma to his/her jaws? YES NO If so, what? _____

Has the Patient had any of the following diseases or medical problems?

- | | | |
|-----------------------------|---------------------------|--------------------------|
| Y N Head or Facial Injury | Y N Heart Murmur/Problems | Y N Cancer/Chemotherapy |
| Y N Tonsillitis | Y N Arthritis | Y N Hearing Disorder |
| Y N Hepatitis/Liver Disease | Y N Venereal Disease | Y N High Blood Pressure |
| Y N Rheumatic Fever | Y N Epilepsy/Seizures | Y N Emotional Problems |
| Y N HIV+/AIDS | Y N Bleeding Problems | Y N Nervous Problems |
| Y N Kidney Disease | Y N Diabetes | Y N Endocrine Problems |
| Y N Allergies or Asthma | Y N Ear Infections | Y N Jaw Joint Pain (TMJ) |
| Y N Metal Allergies | | |

Has the Patient ever sucked a thumb or fingers? YES NO If so, until what age? _____

Have you been informed of any missing or extra permanent teeth? _____

Has an Orthodontist been consulted previously or has the patient had previous Orthodontic treatment? YES NO

If so, by whom? _____

What part of your child's Orthodontic problem concerns you most? _____

Additional information which you feel would make your child's experience with us more enjoyable: _____

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in the medical status of this patient.

Parent Signature _____ Date _____