



**Patient Information Sheet**

Last Name: \_\_\_\_\_ M: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Nickname/Preferred to be called: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 School/Employer: \_\_\_\_\_ Grade/ Position: \_\_\_\_\_  
 Interest/Sports: \_\_\_\_\_

**Primary**       Mother    Father    Step Parent    Self    Other (specify) \_\_\_\_\_  
 Responsible Party: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Address: \_\_\_\_\_ How Long? \_\_\_\_\_  
 Employer/Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_

**Secondary**       Mother    Father    Step Parent    Self    Other (specify) \_\_\_\_\_  
 Responsible Party: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Address: \_\_\_\_\_ How Long? \_\_\_\_\_  
 Employer/Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Social Security: \_\_\_\_\_

How Did You Hear About Us?    Dentist    Patient    Relative    Acquaintance    Other \_\_\_\_\_  
 Whom May We Thank for Referring You to Us? \_\_\_\_\_ Present Dentist: \_\_\_\_\_ Last Seen: \_\_\_\_\_  
 Reason For Consultation: \_\_\_\_\_

Check Yes or No for which the patient has a history:

	Y	N		Y	N		Y	N		Y	N			
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Neck Aches	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Clicking of Jaw	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Sicca	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	TMJ/Jaw Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Painful Chewing	<input type="checkbox"/>	<input type="checkbox"/>	Tooth Grinding	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune	<input type="checkbox"/>	<input type="checkbox"/>	Drug allergies	<input type="checkbox"/>	<input type="checkbox"/>	Immune Problems	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			

If allergies, specify \_\_\_\_\_ Any disease or problems not mentioned above? \_\_\_\_\_  
**Is medication required before dental visits?** \_\_\_\_\_ Current Medications? \_\_\_\_\_  
 Females: Have you started menstruating? \_\_\_\_\_ At what age? \_\_\_\_\_  
 Have wisdom teeth been extracted? \_\_\_\_\_ Any face, mouth or teeth injuries? \_\_\_\_\_  
 Does Patient normally breath through the mouth while awake or asleep? \_\_\_\_\_ Do gums bleed when brushed or flossed? \_\_\_\_\_  
 Has an orthodontist been consulted previously? \_\_\_\_\_ Have you ever had previous orthodontic treatment? \_\_\_\_\_  
 Are there any missing or extra teeth? \_\_\_\_\_ Have the tonsils and adenoids been removed? \_\_\_\_\_  
 Any other questions? \_\_\_\_\_  
 Names and ages of brothers and sisters: \_\_\_\_\_

**\*\*Please notify us immediately if there are any changes to your medical history in the future\*\***

**Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_