

Please complete if patient is a minor:

Parent's or Guardian's Name _____
 Address (in different from patient) _____ Home Phone (in different from patient) _____
 Father Employed by _____ No. of years _____ Position _____
 Mother Employed by _____ No. of years _____ Position _____
 Who will be financially responsible for the orthodontic treatment? _____
 If divorce is involved, who is the custodial parent? _____ May patient information be released to the non-custodial parent? _____

Patient Information:

Patient's Name _____ Birth Date _____
 School (if student) _____ Grade _____
 Employed by _____ No. of years _____ Position _____

Insurance information: I authorize release of any information relating to receiving orthodontic insurance coverage.

Name of insured _____ Birth Date _____ ID# on card _____
 If you don't know the ID #, then SSN _____
 Employer _____ Group # _____
 Insurance Co _____ Phone # _____
 Is there anyone else whose orthodontic insurance might also provide coverage?
 Name of insured _____ Birth Date _____ ID# on card _____
 If you don't know the ID #, then SSN _____
 Employer _____ Group # _____
 Insurance Co _____ Phone # _____

MEDICAL HISTORY

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1) Are you now under a physician's care?
For what reason? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2) Do you pre-medicate with antibiotics for dental visits? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3) Are you currently taking any medications? What? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4) Have you ever been hospitalized?
For what reason? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5) Allergies: latex, food, pollen, drugs, metals, plastics, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6) Any congenital or acquired physical or mental disabilities? What |
| <input type="checkbox"/> | <input type="checkbox"/> | 7) Review of systems – any problems with: head, eyes, ears, nose, throat, heart, lungs, stomach-gut, glands/endocrine, bones, skin, nerves, personality |
| <input type="checkbox"/> | <input type="checkbox"/> | 8) Illnesses (circle): rheumatic fever, mumps, measles, chicken pox, diphtheria, scarlet fever, blood pressure/heart disease, herpes, tonsillitis, hepatitis, VD, HIV/AIDS, influenza, cancer, diabetes, blood problems, TB, epilepsy, rubella. |
| <input type="checkbox"/> | <input type="checkbox"/> | 9) Any history of chronic headaches or pain around ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 10) Any problems with nasal breathing or tonsils and adenoids? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11) Any other information? |

The information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform any necessary dental services that I or my child may need during diagnosis and treatment with my informed consent. I have also received a copy of the office's notice of privacy practices.

Signature _____ **Date** _____

For office use:

I verbally reviewed the medical history with the patient (or parent of minor): _____ Date: _____
 I have read my medical history dated _____ No changes have occurred. Signature: _____ Date: _____
 I have read my medical history dated _____ No changes have occurred. Signature: _____ Date: _____
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*** If Medical History has changed, fill out new medical history form. ***