Date _____

Patient's Name _____ Birthdate _____
First Middle Last

Parent/Guardian Name _____ Relationship to Patient _____

Mailing Address _____
Street City State Zip

E-mail Address (for appointment confirmation/newsletter) _____

Home Phone _____ Cell Phone _____ Work _____

Emergency Contact: _____
Name Relation to Patient Phone

YES	NO	MEDICAL HISTORY
_____	_____	Are you under a doctor's care? If yes, why? _____
_____	_____	Is there any history of major illness? If yes, what? _____
_____	_____	Any drugs or medication currently in use? What? _____
_____	_____	Are there any drug sensitivities? List: _____
_____	_____	Do you have any allergies? (including nickel sensitivity) List: _____
_____	_____	Are you sensitive to latex?
_____	_____	Do you have a tendency to colds, sore throats, or ear infections?
_____	_____	Do you smoke?
_____	_____	Do you snore?
_____	_____	Do you have sleep apnea?
_____	_____	Are you HIV positive?
_____	_____	Are you pregnant?

Name of general dentist: _____ Date of last exam: _____

YES	NO	DENTAL HISTORY
_____	_____	Have there been any injuries to the face, mouth or teeth?
_____	_____	Have you ever had speech therapy?
_____	_____	Are you a mouth breather?
_____	_____	Were you or are you currently a thumb sucker?
_____	_____	Have any teeth been extracted? Why? _____
_____	_____	Have you had any adverse effect to dental anesthesia?
_____	_____	Have you been treated for gum disease?
_____	_____	Have you had previous orthodontic treatment or consultation? When? _____
_____	_____	Do you play any musical instrument? What type? _____
_____	_____	Do you clench or grind your teeth?
_____	_____	Does your jaw click or pop?
_____	_____	Is there difficulty opening wide?
_____	_____	Does your jaw ever stick so you can't close?
_____	_____	Does it hurt to chew?
_____	_____	Is there pain in front of your ears?
_____	_____	Is there cheek or temple pain?
_____	_____	Do you suffer from headaches?
_____	_____	Do you have neck or shoulder pain?

What are your concerns about your teeth or jaw? _____

_____

I have completed this form to the best of my knowledge. _____ _____
Signature Date

Reviewed by: _____ Date _____