

PATIENT INFORMATION

PATIENT'S FULL NAME _____
NICKNAME _____ DATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ BIRTHDATE _____ SSN# _____
If Patient is a minor, please give parents' or guardians' name(s) _____
NAMES OF OTHER FAMILY MEMBERS WE HAVE TREATED _____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

MEDICAL HISTORY

HAS THE PATIENT EVER BEEN TREATED FOR THE FOLLOWING?

Diabetes	Yes No	Tuberculosis	Yes No	Endocrine or Thyroid	Yes No
Pneumonia	Yes No	Anemia	Yes No	Prolonged Bleeding	Yes No
Heart failure	Yes No	Epilepsy	Yes No	Liver disease	Yes No
Bone disorders	Yes No	Asthma	Yes No	Fainting or Dizziness	Yes No
Rheumatic Fever	Yes No	Kidney disease	Yes No	Nervous disorders	Yes No

IS THE PATIENT IN GOOD HEALTH? _____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN AND PLEASE GIVE REASONS _____

DOES THE PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____

PLEASE LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____

HOW MUCH GROWTH HAS OCCURRED IN THE LAST 6 MONTHS? _____

HAS THE PATIENT REACHED PUBERTY? _____

HEIGHT: PATIENT _____ MOTHER _____ FATHER _____

PATIENT'S PHYSICIAN _____ LAST SEEN _____

DENTAL HISTORY

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH, OR TEETH? YES NO. IF YES, WHAT WAS INJURED? _____

HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE? _____

DOES THE PATIENT CLENCH OR GRIND THEIR TEETH? YES NO

DOES THE PATIENT HAVE ANY CLICKING OR DISCOMFORT IN THE JAW JOINTS? YES NO

HAVE YOU EVER BEEN INFORMED OF ANY MISSING OR EXTRA TEETH? YES NO

HAS THE PATIENT HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS? YES NO

IS THE PATIENT ANXIOUS TOWARD DENTAL VISITS? YES NO

DOES THE PATIENT HAVE ANY CONGENITAL ABNORMALITIES? YES NO. IF YES, PLEASE EXPLAIN _____

PATIENT'S DENTIST _____ LAST SEEN _____

RESPONSIBLE PARTY INFORMATION

NAME _____

MARITAL STATUS _____ SPOUSE'S NAME _____

MAILING ADDRESS _____

HOW LONG AT THIS ADDRESS? _____ HOME PHONE (w/ area code) _____

PREVIOUS ADDRESS (If less than 3 years) _____

HOW LONG AT YOUR PREVIOUS ADDRESS? _____

RELATIONSHIP TO PATIENT IF APPLICABLE _____

RESPONSIBLE PARTY'S DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____

OF YEARS EMPLOYED _____

EMPLOYER ADDRESS AND PHONE NUMBER (w/ area code) _____

PREVIOUS EMPLOYER ADDRESS AND PHONE NUMBER (If less than 3 years) _____

INSURANCE INFORMATION

INSURED'S NAME _____ INSURANCE CO _____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

COMPLETE ADDRESS AND PHONE # _____

I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT. IF THERE ARE ANY CHANGES I WILL NOTIFY DR. ALTHERR'S OFFICE.

Signature

Date