

PATIENT INFORMATION

Legal Name: _____ Preferred Name: _____
 Birthdate: _____ Age: _____ Sex: M F
 Address: _____ City/State/Zip: _____
 Home Phone: _____ Email: _____
 Employer: _____ Job Title: _____
 Are there other family members that came to our office? _____
 Dentist Name: _____ Who can we thank for referring you? _____
 How do you wish to receive appointment reminders? Email: _____
 Text: #1 _____ #2 _____ #3 _____

RESPONSIBLE PARTY INFORMATION

Patient's Information:

Name: _____
 Date of Birth: _____ Social Security #: _____
 Address (if different than above): _____ City/State/Zip: _____
 Home Phone: _____ Cell Phone: _____
 Work Phone: _____ Email: _____

Spouses Information:

Name: _____
 Date of Birth: _____ Social Security #: _____
 Address (if different than above): _____ City/State/Zip: _____
 Home Phone: _____ Cell Phone: _____
 Work Phone: _____ Email: _____

MEDICAL HISTORY

PLEASE INDICATE WHETHER OR NOT YOU HAVE EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS BY CIRCLING (Y)es or (N)o.

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	ADD/ADHD	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	AIDS/Antibody Positive
Y	N	Congenital Heart Defect	Y	N	Kidney Problems
Y	N	Infective Endocarditis	Y	N	Liver Problems
Y	N	Cancer	Y	N	Lupus
Y	N	Convulsions/Epilepsy	Y	N	Migraine Headaches
Y	N	Diabetes	Y	N	Rheumatic/Scarlet Fever
Y	N	Emotional Problems	Y	N	Sickle Cell Disease/Traits
Y	N	Hearing Impairment	Y	N	Tuberculosis
Y	N	Heart Murmur	Y	N	Tonsils Removed-Age: _____
Y	N	Asthma			

ALLERGIES: Y N Medications- If yes, please list: _____
Y N Latex Y N Metals Y N Plastic/Acrylic

Are you currently being seen for any injury or illness? Y N- If yes, please explain: _____
Are there any other medical concerns we should be aware of? Y N-If yes, please explain: _____
Do you need to be pre-medicated prior to dental visits? Y N – If yes, do you have prescription filled: Y N

Name of Physician: _____ Phone: _____

Please list any medication(s) patient is currently taking, along with reason for the medication(s):

DENTAL HISTORY

When did you last visit the dentist? _____

Why are you seeking an orthodontic consultation? _____

Have you ever had prior orthodontic consultation or treatment? Y N- If yes, please explain: _____

Is there a history of thumb or finger sucking? Y N- If yes, until what age? _____

Do you have any speech problems? Y N- If yes, are you currently in speech therapy? Y N

Have you ever had a severe head, neck or facial injury? Y N- If yes, please explain: _____

Do you ever:

Experience frequent headaches? Y N- If yes, please explain: _____

Pain or clicking in the jaw joint? Y N- If yes, please explain: _____

Do you clench or grind your teeth? Y N- If yes, please explain: _____

Have you been informed of any missing or extra permanent teeth? Y N- If yes, please explain: _____

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that is my responsibility to inform the office of Paul W Reed, DDS, MS, PC of any changes in the patient's medical status. I authorize the team of Paul W Reed, DDS, MS, PC to take x-rays and photos that may be needed during diagnosis and treatment, with my informed consent.

Signature of Patient: _____ Today's Date: _____