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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Information and Health History Form (part 1)** | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **Patient Information** | | | | | | | | | | |
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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **First Name** |  |  |  | **Nick Name** |  |  | **Last Name** | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **\_\_\_\_\_\_\_\_\_\_** | |  |  |  | |  | | --- | |  | |  |  |  |
| **Date of Birth** | | **Gender** |  |  | **Are you on Facebook?** | | |  |  |
|  |  |  |  |  |  |  | **Yes** | **No** |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Address** |  |  |  |  |  |  | **City** |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | **\_\_\_\_\_\_\_\_\_\_** | | **\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Address Line 2** | |  |  |  |  |  | **State** |  | **Zip Code** |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| |  | | --- | |  | | **Cell Phone** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |  | | --- | |  | | **Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
|  |  |  | **Check Primary Phone** |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **Person bringing Patient to their appointment:** | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Patient's chief concern:** | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **If invisalign? Are you interested in conventional braces?** | | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Who referred you?** | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **General Dentist Name:** | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |  | **Last checkup Date\_\_\_\_\_\_\_\_\_\_\_** | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **Dentist address and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Previous orthodontic consult?** | | | |  | | --- | |  | | **Previous Orthodontist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |  |
|  |  |  | **Yes** | **No** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Responsible Party A Information** | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **\_\_\_\_\_\_\_\_\_** |
| **Relationship** | | **First Name** | |  |  | **Last Name** |  |  |  | **DOB** |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | **\_\_\_\_\_\_\_\_\_\_\_** | |
| **Address** |  |  |  |  |  |  |  |  | **State** |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **\_\_\_\_\_\_\_\_\_\_\_** | |
| **Address Line 2** | |  |  |  |  | **City** |  |  | **Zip Code** |  |
|  |  |  |  |  |  |  |  |  |  |  |
| |  | | --- | |  | |  |  |  |  |  |  |  |  |  |  |
|  | **Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
|  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | |  |
| **E-mail address** | |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **SSN** |  | **Occupation** | |  | **Employer** |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Responsible Party B Information** | | | | | | | | | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **\_\_\_\_\_\_\_\_\_** |
| **Relationship** | | **First Name** | |  |  | **Last Name** |  |  |  | **DOB** |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | **\_\_\_\_\_\_\_\_\_\_\_** | |
| **Address** |  |  |  |  |  |  |  |  | **State** |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **\_\_\_\_\_\_\_\_\_\_\_** | |
| **Address Line 2** | |  |  |  |  | **City** |  |  | **Zip Code** |  |
| |  | | --- | |  | |  |  |  |  |  |  |  |  |  |  |
|  | **Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **E-mail address** | |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **SSN** |  | **Occupation** | |  | **Employer** |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Patient Information and Health History Form (part 2)** | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **First Name** |  |  |  |  |  | **Last Name** | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Dental Insurance available for orthodontics? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | **May we check this for you \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **Are insurance subscriber and responsible party the same? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Subscriber (if different than RP)** | | |  |  | **Insurance Company** | |  |  | **Group Number** | |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **SSN** |  |  | **Date of Birth** | |  | **Phone Number (Insurance)** | | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Subscriber 2 (if different than RP)** | | |  |  | **Insurance Company 2** | |  |  | **Group Number 2** | |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **SSN 2** |  |  | **Date of Birth 2** | |  | **Phone Number 2 (Insurance)** | | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Medical History** | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **Major Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **Any Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **Accidents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **Abnormal Bleeding/ Hemophilia** | | | **\_\_\_\_\_** | **Gastrointestinal Disorders** | | | **\_\_\_\_\_** | **Nervous Disorders** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  | **Anemia** | **\_\_\_\_\_** | **Heart Problems** | | | **\_\_\_\_\_** | **Pneumonia** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  | **Arthritis** | **\_\_\_\_\_** | **Heart Murmur** | | | **\_\_\_\_\_** | **Radiation/Chemotherapy** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
|  | **Asthma or Hayfever** | | **\_\_\_\_\_** | **Hepatitis/Liver Problem** | | | **\_\_\_\_\_** | **Rheumatic Fever** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
|  | **Bone Disorders** | | **\_\_\_\_\_** | **Herpes** | | | **\_\_\_\_\_** | **Tuberculosis** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
| **Congenital Heart Defect** | | | **\_\_\_\_\_** | **High Blood Pressure** | | | **\_\_\_\_\_** | **Tumor or Cancer** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  | **Diabetes** | **\_\_\_\_\_** | **HIV / Aids** | | | **\_\_\_\_\_** |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  | **Epilepsy** | **\_\_\_\_\_** | **Kidney Problems** | | | **\_\_\_\_\_** |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Other Conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **Dental History** | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
| **Apprehensive about dental care** | | | **\_\_\_\_\_** | **Discomfort from teeth or gums** | | | **\_\_\_\_\_** | **Brush daily** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
| **Presently in dental pain** | | | **\_\_\_\_\_ Pain, tenderness or noise in either jaw** | | | | **\_\_\_\_\_** | **Floss daily** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
| **Unfavorable reaction to dentistry** | | | **\_\_\_\_\_** | **Grind or clench teeth** | | | **\_\_\_\_\_** | **Fluoride treatments** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
| **Missing or extra permanent teeth** | | | **\_\_\_\_\_** | **Frequent sore throats** | | | **\_\_\_\_\_** | **Frequently chew gum** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
| **Injury to face, jaw, teeth, or mouth** | | | **\_\_\_\_\_** | **Speech problems / therapy** | | | **\_\_\_\_\_** | **Requires premedication** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
| **Bleeding gums** | | | **\_\_\_\_\_** | **Snores during sleep** | | | **\_\_\_\_\_** |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Oral habits** | | | **\_\_\_\_\_** | **Frequent headaches** | | | **\_\_\_\_\_** | **PREGNANT** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
| **Mouth breathing** | | | **\_\_\_\_\_** | **Neck /shoulder pain** | | | **\_\_\_\_\_** | **Menstruation Started** | | **\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Signature** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | **Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |