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| **Patient Information and Health History Form (part 1)** |
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| **Patient Information** |
|  |  |  |  |  |  |  |  |  |  |  |
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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **First Name** |  |  |  | **Nick Name** |  |  | **Last Name** |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_** |  |  |  |

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| **Date of Birth** | **Gender** |  |  | **Are you on Facebook?** |  |  |
|  |  |  |  |  |  |  |  **Yes** |  **No**  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Address** |  |  |  |  |  |  | **City** |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Address Line 2** |  |  |  |  |  | **State** |  | **Zip Code** |  |
|  |  |  |  |  |  |  |  |  |  |  |
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 | **Cell Phone** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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 | **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?** |

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 | **Previous Orthodontist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
|  |  |  | **Yes** | **No** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Responsible Party A Information** |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| **Relationship** | **First Name** |  |  | **Last Name** |  |  |  | **DOB** |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| **Address** |  |  |  |  |  |  |  |  | **State** |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| **Address Line 2** |  |  |  |  | **City** |  |  | **Zip Code** |  |
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|  | **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** |  |
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|  | **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |