Date _____ 20____

Patient's name _____ Birthdate _____ Age _____ Sex _____

Res. address _____ Zip _____ Phone _____

Mother's Cell Phone _____ Father's Cell Phone _____

**TO BE FILLED OUT IF PATIENT IS A MINOR:**

Father's name _____ DOB _____ SS# _____

Employer _____ Occupation _____ Bus. Phone _____

Mother's name _____ DOB _____ SS# _____

Employer _____ Occupation _____ Bus. Phone _____

Do mother, father, and child live together? _____ Yes _____ No

If not, with whom does the child live? _____

Person financially responsible for account? _____

School attended _____ Grade _____

Names and ages of brothers/sisters _____

**TO BE FILLED OUT IF PATIENT IS AN ADULT:**

Employer _____ Occupation _____ Bus. Phone _____

Business address _____ SS# _____

Spouse's name if married _____ SS# _____

Employer _____ Occupation _____ Bus. Phone _____

**FOR ALL PATIENTS:**

Has the patient had a previous orthodontic consultation or treatment? _____ Yes _____ No

If yes, when _____ and by whom _____?

Problems or concerns? _____

Has this office rendered treatment to any member of your family? _____

Please list names: _____

General dentist's name _____

Whom may we thank for your referral to our office? _____

**MEDICAL HISTORY:**

Height: _____ Weight _____

Physician's name _____ Date of last check up _____

____ Yes ____ No Is patient in good health? _____

____ Yes ____ No Does patient have any history of major illness? _____

Explain _____

____ Yes ____ No Does patient have any food or drug allergies?

Explain _____

____ Yes ____ No Has the patient ever been hospitalized?

Explain _____

____ Yes ____ No Has the patient ever received a blood transfusion?

____ Yes ____ No Is the patient currently taking any medications?

List name and dosage _____

**FOR GROWING PATIENTS ONLY:**

Female patients

____ Yes ____ No Has patient started her monthly period? Age started ____

____ Yes ____ No Has patient any other signs of pubertal development?

(axillary hair, etc.)

Male patients

____ Yes ____ No Has patient's voice changed?

____ Yes ____ No Has patient started to shave?

____ Yes ____ No Has patient shown other signs of pubertal development?

(axillary hair, etc.)

**INDICATE ANY PAST OR PRESENT CONDITIONS:**

| | | | | | |
|---|---|---|---|---|---|
| _____ Yes | _____ No | Anemia | _____ Yes | _____ No | Hemophilia |
| _____ Yes | _____ No | Asthma | _____ Yes | _____ No | Hepatitis |
| _____ Yes | _____ No | Auto Immune Deficiency | _____ Yes | _____ No | High blood pressure |
| _____ Yes | _____ No | Bleeding tendency | _____ Yes | _____ No | Hyperactivity |
| _____ Yes | _____ No | Blood disease | _____ Yes | _____ No | Kidney disease |
| _____ Yes | _____ No | Bone disorders | _____ Yes | _____ No | Liver disease (jaundice) |
| _____ Yes | _____ No | Convulsions | _____ Yes | _____ No | Lung disease |
| _____ Yes | _____ No | Diabetes | _____ Yes | _____ No | Mental retardation |
| _____ Yes | _____ No | Ear disorders | _____ Yes | _____ No | Muscle disorders |
| _____ Yes | _____ No | Emotional problems | _____ Yes | _____ No | Nose/Throat disorders |
| _____ Yes | _____ No | Endocrine disorders | _____ Yes | _____ No | Rheumatic Fever |
| _____ Yes | _____ No | Epilepsy | _____ Yes | _____ No | Skin disease |
| _____ Yes | _____ No | Eye disorders | _____ Yes | _____ No | Sickle-Cell Anemia |
| _____ Yes | _____ No | Heart condition/murmur | _____ Yes | _____ No | Stomach problems |
| Other _____ | | | _____ Yes | _____ No | Tumors |

_____

**DENTAL HISTORY:**

_____ Yes _____ No Has patient ever sucked thumb or fingers? Until what age? _____
_____ Yes _____ No Does patient breathe predominately through the mouth?
_____ Yes _____ No Does patient have any speech problems?
_____ Yes _____ No Does patient have any noticeable difficulty in chewing or swallowing food?
_____ Yes _____ No Does patient clench or grind teeth during the day or night?
_____ Yes _____ No Does patient have pain or clicking upon opening or closing mouth?
_____ Yes _____ No Does patient notice bleeding of gums while brushing?
_____ Yes _____ No Has patient had any severe head or face injuries?
_____ Yes _____ No Have any teeth been injured due to an accident?
_____ Yes _____ No Have you been informed of any missing permanent teeth?
_____ Yes _____ No Have you been informed of any extra teeth?
_____ Yes _____ No Does anyone in the family have a similar dental problem?
_____ Yes _____ No Does the patient want his/her teeth straightened?
_____ Yes _____ No Has any member of the family had orthodontic treatment?
If so, who? _____

**CONSENT:**

I acknowledge that the above information is correct and authorize Dr. Barbara Utermark and staff to provide dental and related medical/surgical treatment as deemed necessary utilizing proper and acceptable methods to complete same including diagnostic radiographs and photographs. I understand that some appointments will infringe upon school or work hours and that payment is expected as services are rendered. Method of Payment: ☐ Check, ☐ Cash, ☐ Credit Card.

Patient signature _____ Date _____

Parent/Legal guardian if patient is a minor:

_____ Date _____