PATIENT:

Preferred Name:

BIRTHDATE: AGE:

PHONE: Home/Cell/Work (Circle one)

RESPONSIBLE PARTY: PHONE:

Home/Cell/Work (Circle one)

Address:

Email: (for appointment reminders)

OTHER CONTACT:____
(spouse, 2nd guardian, etc.)

Phone: _________________________Home/Cell/Work (Circle one)

Address: __________________________________

____

WHO CAN WE THANK FOR YOUR REFERRAL? _________________________

PATIENT'S DENTIST:

DATE OF LAST DENTAL VISIT:_______________________________________

MEDICAL HISTORY

PATIENT NAME:

Family Physician/Pediatrician____

Address____

Last Exam_________________________Phone__________________________

Patient: If yes, please explain:

Is currently under treatment?	No / Yes___________________
Is currently taking medications?	No / Yes___________________
Is allergic to any food/medication?	No / Yes___________________
Has any other severe known allergies?	No / Yes___________________
Has had tonsils/adenoids removed?	No / Yes___________________

Anemia	No / Yes	Speech Problems	No / Yes
Asthma	No / Yes	Nail Biting	No / Yes
Bleeding Problems	No / Yes	Injuries to Face/Mouth	No / Yes
Bone Disorders	No / Yes	Facial Pain/Discomfort	No / Yes
Diabetes	No / Yes	Mouth Breathing	No / Yes
Endocrine Disorders	No / Yes	Grinding	No / Yes
Epilepsy	No / Yes	Clicking/Jaw Popping	No / Yes
Fainting or Dizziness	No / Yes		
Frequent Headaches	No / Yes		
Heart Disorders	No / Yes		
Kidney Disorders	No / Yes		
Liver Involvement	No / Yes		
Rheumatic Fever	No / Yes		
Smoking	No / Yes		

Other:____

Please explain if any YES answers above:

____

Are there any other medical concerns you have?

____

Emergency Contact Information:

Name:_________________________________Relationship:___________________

Address:______________________________Cell #:_________________________