Date_____

Patient Information

Name_____Preferred Name_____

Address_____City_____State_____Zip_____

Date of Birth_____ Sex_____General Dentist/Office_____

Phone_____

Email_____

Employer_____

Orthodontic Insurance Yes_____ No_____

Marital Status: Single_____ Married_____ Divorced_____ Widow(er)_____

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Spouse Information

Name_____

Date of Birth_____ Phone_____

Email_____

Employer_____

Orthodontic Insurance Yes_____ No_____

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Patient Physician_____ **Clinic**_____

Have you been hospitalized in the last 5 years? No_____ Yes_____ Reason_____

Are you currently under a physician's care? No_____ Yes_____ Reason _____

Are you currently taking any medications? (please list)_____

_____

MEDICAL INFORMATION
(please circle all that apply)

Abnormal Bleeding	ADHD	Angina
Anemia	ADD	Artificial Valve
Hepatitis	Anxiety	Heart Murmur
HIV/AIDS	Autism	Heart Surgery
Sexually Transmitted Disease	Chemical Dependency	Heart Valve Prolapse
Diabetes	Depression	Joint Replacement or Implant
Epilepsy	Celiac Disease	Pacemaker
Airway/Respiratory Disease	Eating Disorder	Rheumatic Fever
Asthma	Gastrointestinal Disease	Low Blood Pressure
Latex Allergy	Kidney Disease	High Blood Pressure
Metal Allergy	Liver Disease	Thyroid Disease
Arthritis	Cancer (Please Specify):_____	Pregnant? (Due Date)_____

Other_____

Are Antibiotics required for Dental procedures? Yes_____ No _____

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Please list any other conditions, problems or allergies not listed above: _____
_____
_____

Describe any problems with your jaw:
Clicking? _____
Pain? (joint, ear, side of face?) _____
Frequent Headaches?_____
Jaw locked or popped? _____
Do you clench or grind their teeth? _____
Have you had T.M.J. Therapy? _____

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Patient Signature_____