Patient Information (MINOR) Date_____

Name_____Preferred Name_____

Address_____City_____State_____Zip_____

Date of Birth_____ Sex_____General Dentist/Office_____

Patient Lives with: Both Parents _____ Mom _____ Dad _____ Other (please specify) _____

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Parent/Guardian 1

Name_____

Address (if different than patient)_____

Relationship to Patient_____Date of Birth_____

Phone_____Email_____

Employer_____ Orthodontic Insurance Yes_____ No_____

Single_____ Married_____ Divorced_____

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Parent/Guardian 2

Name_____

Address (if different than patient)_____

Relationship to Patient_____Date of Birth_____

Phone_____Email_____

Employer_____ Orthodontic Insurance Yes_____ No_____

Single_____ Married_____ Divorced_____

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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_____		

Patient Physician_____ Clinic_____

Is your child currently taking any medications? (please list) _____

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 child's jaw:
Clicking? _____
Pain? (joint, ear, side of face?) _____
Frequent Headaches?_____
Jaw locked or popped? _____
Does your child clench or grind their teeth? _____
Has your child had T.M.J. Therapy? _____

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Parent/Guardian Signature_____