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PATIENT INFORMATION AND HEALTH HISTORY

Date_____

Patient Name_____Date of Birth_____

Person Responsible for this Account_____

Address_____
Street Apt/Unit# City Zip Code

Employed By_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____ Preferred Contact (circle) Home / Cell / Work / Email
May I leave a voicemail? Y N

Patient's School_____
Name City

Current Grade/Year in School_____ Patient Age Today_____

Referred By_____

DENTAL HISTORY

Primary Oral Complaint_____
Dentist's Name_____
Dentist's Address_____
Street City Zip Code
Dentist's Phone_____ Date of Last Dental Exam_____

Do you or does your child have/use any of the following?

___Clenching/Grinding
___Frequent chapped lips
___Frequent blisters on lips or mouth
___Pain around ear
___Frequent headaches
___Unusual sounds in ear while eating
___Mouth-breathing
___Oral habits e.g., nail biting, thumb sucking
___Unfavorable dental experience
___Frequency of brushing_____
___Orthodontic Treatment

___Other:

MEDICAL HISTORY

Physician's Name_____ Phone_____
Address_____
Street City Zip Code
Date of Last Physical Exam_____

Do you or does your child have any of the following?

___Allergies to drugs
___ Tonsillectomy and/or Adenoidectomy
___Diagnosed allergies
___Neurological problems
___History of ear infections
___Sinus problems
___Hearing Loss
___Frequent strep/tonsillitis
___Sleep difficulties
___Psychiatric/Emotional problems
___Asthma

___Current Diagnosis:
___Other: