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 "Dr. Sam"
 Orthodontics

CHART NO. _____ Referred By _____ Date _____
 Patient's Name _____ Preferred Name _____
 Birthday _____ Age _____ Sex _____
 Patient's Dentist _____ Physician _____
 SSN _____
 Home Address _____ Home Phone _____
 _____ Work Phone _____
 Occupation _____ Employed By _____

Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Widow(er) _____
 Names of any family members we have seen _____
 Dental Insurance? Yes _____ No _____ If yes, what company _____
 Person(s) responsible for payment of account _____
 Address and relationship to Patient _____

MEDICAL HISTORY

Are you in good health? _____ Do you have any history of major illness? _____
 Please list (give dates) _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

- | | | | |
|---|---------------------------------------|--|--|
| HEART TROUBLE <input type="checkbox"/> | HIV/AIDS <input type="checkbox"/> | ATTENTION DEFICIT <input type="checkbox"/> | LIVER INVOLVEMENT <input type="checkbox"/> |
| MITRAL VALVE PRO <input type="checkbox"/> | ANEMIA <input type="checkbox"/> | KIDNEY PROBLEMS <input type="checkbox"/> | HEPATITIS <input type="checkbox"/> |
| HEART MURMUR <input type="checkbox"/> | EPILEPSY <input type="checkbox"/> | ENDOCRINE PROBLEMS <input type="checkbox"/> | BLOOD DISORDERS <input type="checkbox"/> |
| RHEUMATIC FEVER <input type="checkbox"/> | ASTHMA <input type="checkbox"/> | PROLONGED BLEEDING <input type="checkbox"/> | DIABETES <input type="checkbox"/> |
| PNEUMONIA <input type="checkbox"/> | TUBERCULOSIS <input type="checkbox"/> | FAINTING OR DIZZINESS <input type="checkbox"/> | OTHER _____ <input type="checkbox"/> |

Do you have a tendency to: Colds _____ Sore Throat _____ Ear Infections _____ Cold Sores _____
 Have tonsils and adenoids been removed? _____ What Age? _____ List any drugs or medications now being taken
 and reason. _____
 LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

DENTAL HISTORY

Date of last dental cleaning _____ Date of last X-rays _____
 Have you had a Panoramic/Panorex X-ray Y / N / Don't know If yes, When? _____
 Have there been injuries to the face, mouth or teeth? Y / N If yes, describe and give the date _____
 _____ Did you ever suck a thumb or fingers? Y / N Age _____
 Any pain in or near the ears? Y / N
 Interests or hobbies _____

Signature _____