



Samuel G. Smith, DMD, MS
"Dr. Sam"
Orthodontics

CHART NO. _____ Referred By _____ Date _____

Patient's Name _____ Preferred Name _____

Birthday _____ Age _____ Sex _____ School _____ Grade _____

Patient's Dentist _____ Physician _____

Mother's Name _____ SSN _____ DOB _____

Home Address _____ Home Phone _____

(City/State/Zip) _____ Work Phone _____

Occupation _____ Employed By _____

Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Widow(er) _____

Father's Name _____ SSN _____ DOB _____

Home Address _____ Home Phone _____

(City/State/Zip) _____ Work Phone _____

Occupation _____ Employed By _____

Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Widow(er) _____

Names of any family members we have seen _____

Names and ages of other children in the family _____

Person(s) responsible for payment of account _____

Address and relationship to Patient _____

Primary Insurance Carrier _____ Insurance Phone # _____

Address _____ Group # _____

Name of Person Insured _____ Secondary Insurance Carrier _____

MEDICAL HISTORY

Is the patient in good health? _____ Does the patient 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"/> |

Does patient have 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 _____

Has the patient reached puberty: Girls-has she started menstruation _____ Date of onset _____

Boys-has his voice changed _____

DENTAL HISTORY

Date of last dental cleaning _____ Date of last X-rays _____

Has the patient 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 _____

_____ Has the patient ever sucked a thumb or fingers? Y/N Age _____

Any pain in or near the ears? Y/N _____ Has either patient had orthodontic treatment? Y/N _____

List any musical instruments played _____

Interests or hobbies _____

Signature (parent or guardian's) _____