PLEASE PRINT (Complete & Bring to Your First Visit) ______________________________

DATE ______________________ RECALL CHART NO.

PATIENT____
FIRST MIDDLE LAST NICKNAME

MALE____FEMALE ____AGE________BIRTHDATE________________PHONE ______________________________
M D YR CELL ______________________________

ADDRESS____
NUMBER AND STREET CITY/STATE ZIP

SINGLE_____ MARRIED_____ DIVORCED______

EMPLOYED BY/SCHOOL____

BUSINESS ADDRESS____
PHONE

EMAIL____

____
FATHER'S NAME ADDRESS, CITY, STATE & ZIP PHONE-HOME CELL

SOCIAL SECURITY#____

____
FATHER'S EMPLOYER OCCUPATION BUSINESS PHONE

____
MOTHER'S NAME ADDRESS,CITY, STATE & ZIP PHONE-HOME CELL

SOCIAL SECURITY#____

____
MOTHER'S EMPLOYER OCCUPATION BUSINESS PHONE

RESPONSIBLE PARTY____
ADDRESS

ORTHODONTIC INSURANCE________________________________SUBSCRIBER #______________________________

FAMILY DENTIST____

HAVE ANY OTHER CHILDREN BEEN SEEN AT OUR OFFICE? ______________________________
NAMES____

DID YOUR DENTIST, FRIEND OR ADVERTISEMENT REFER YOU TO US; WHO CAN WE THANK?
____

WHY HAVE YOU SELECTED OUR OFFICE FOR YOUR CARE? ______________________________

____

WHAT WOULD YOU LIKE DONE?____

PATIENT'S MEDICAL HISTORY

HABITS- THUMB SUCKER _____MOUTH BREATHER _____SPEECH IMPEDIMENT _____HEART MURMUR_______

HAD- RHEUMATIC FEVER _______BLEEDING DISORDER ______ HEART DISEASE _____ ASTHMA___________

TONSILS- PRESENT ____REMOVED, WHEN______________________________

PREGNANT NO ____YES_____ IS PATIENT IN GOOD HEALTH? ______________________________

REACTION TO MEDICINE?______________________ALLERGIES?______________________________

OTHER____
ANY OTHER SERIOUS OR RECURRENT ILLNESS (PHYSICAL OR MENTAL)