MEDICAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (Check YES or NO)

AIDS	☐ Y ☐ N	Diabetes	☐ Y ☐ N	HIV Infection	☐ Y ☐ N
Anemia	☐ Y ☐ N	Emotional Problems	☐ Y ☐ N	Kidney Disorders	☐ Y ☐ N
Arthritis	☐ Y ☐ N	Endocrine Disorders	☐ Y ☐ N	Latex Sensitivity	☐ Y ☐ N
Artificial Heart Valve	☐ Y ☐ N	Epilepsy (Convulsions)	☐ Y ☐ N	Liver Disease	☐ Y ☐ N
Artificial Joints	☐ Y ☐ N	Frequent Headaches	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N
Asthma	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Neurologic Disorders	☐ Y ☐ N
Blood Disorders	☐ Y ☐ N	Heart Murmur/Heart Problems	☐ Y ☐ N	Respiratory Problems	☐ Y ☐ N
Blood Transfusions	☐ Y ☐ N	Hemophilia	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N
Bruise Easily	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Thyroid Problems	☐ Y ☐ N
Cerebral Palsy	☐ Y ☐ N	Herpes	☐ Y ☐ N	Tonsil / Adenoid Removal	☐ Y ☐ N
Congenital Heart Disease	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N

STATE ANY REASONS WHY THE PATIENT IS CURRENTLY UNDER THE CARE OF A PHYSICIAN _____

LIST ANY MEDICATIONS THAT THE PATIENT IS CURRENTLY TAKING _____

LIST ANY DRUG ALLERGIES OR SENSITIVITIES _____

HAS THE PATIENT BEEN ADVISED THAT ANTIBIOTICS SHOULD BE TAKEN PRIOR TO DENTAL PROCEDURES? (YES or NO) _____

LIST ANY OTHER SERIOUS ILLNESSES, OPERATIONS OR DISEASES NOT LISTED ABOVE _____

DEVELOPMENTAL HISTORY

PATIENT'S HEIGHT _____ PATIENT'S WEIGHT _____ FATHER'S HEIGHT _____ MOTHER'S _____

HAS PATIENT REACHED PUBERTY? _____ IF YES, WHEN? _____

IS PATIENT ADOPTED? _____

DENTAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (Check YES or NO)

Bleeding Gums	☐ Y ☐ N	Jaw Joint Pain	☐ Y ☐ N	Nail Biting	☐ Y ☐ N
Chronic Facial Pain	☐ Y ☐ N	Jaw Joints Pop or Click	☐ Y ☐ N	Periodontal Surgery	☐ Y ☐ N
Clenching or Grinding of Teeth	☐ Y ☐ N	Jaw Locking Open or Closed	☐ Y ☐ N	Perm. Teeth Removed	☐ Y ☐ N
Difficulty Chewing/Swallowing	☐ Y ☐ N	Limitation in Mouth Opening	☐ Y ☐ N	Speech Problems	☐ Y ☐ N
Dizziness	☐ Y ☐ N	Missing/Extra Permanent Teeth	☐ Y ☐ N	Sucks Thumb, Finger or Lip	☐ Y ☐ N
Facial Paralysis	☐ Y ☐ N	Mouth Breathing	☐ Y ☐ N	Teeth Sensitivity - Hot/Cold	☐ Y ☐ N
Injuries to Face or Teeth	☐ Y ☐ N	Muscle Tenderness in Jaw/Neck	☐ Y ☐ N	Tongue Thrust	☐ Y ☐ N

DATE OF LAST VISIT _____

LIST ANY DENTAL PROBLEMS WE SHOULD KNOW ABOUT _____

LIST THE PATIENT'S CHIEF CONCERNS AND WHAT THEY WOULD LIKE THIS ORTHODONTIC TREATMENT TO ACCOMPLISH

AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical or dental insurance. I authorize release of any information to insurance carriers and to other health care providers involved in my child's care. I authorize Dr. Foley and the dental staff to perform any necessary dental services that are needed during diagnosis and treatment. I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE (IF MINOR, PARENT'S SIGNATURE) _____ **DATE** _____

FOR OFFICE USE
UPDATES (DATE AND INITIAL)

DOCTOR SIGNATURE _____ **DATE** _____