



Adolescent Patient Information

1	About You
Today's date: ____/____/____	
Patient Name: _____	
Nickname: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: ____/____/____ Social Security # _____	
Street Address: _____ City _____ State _____ ZIP _____	
School: _____ Sports/Hobbies: _____	
Referred by: _____ Dentist name: _____	

2	Responsible Party Information
Name: _____ Relationship to Patient _____	
Address: _____	
Phone #: _____ Cell #: _____ Work #: _____	
Social Security #: _____ Date of Birth _____ E-mail : _____	
Employer: _____ Occupation _____	
Spouse's Name: _____ Relationship to Patient: _____	
Phone # _____ Work #: : _____ Cell#: _____	

3	Primary Dental Insurance
Insurance Company: _____ Address: _____	
Phone #: _____ Group #: _____ Subscriber ID or SS# _____	
Insured's Name: _____ Relationship: _____ Date of Birth: ____/____/____	
Insured's Employer: _____ Address: _____	
Phone #: _____ Group #: _____ Is there Dual coverage? _____	

Medical and Dental History

Patient Name: _____		
Birthdate: _____		
Yes/No	Yes/No	Yes/No
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Asthma/ Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> <input type="checkbox"/> Cancer/ Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/> Drug/ Alcohol Abuse	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> <input type="checkbox"/> Epilepsy/ Seizures	<input type="checkbox"/> <input type="checkbox"/> Fever Blisters/ Herpes	<input type="checkbox"/> <input type="checkbox"/> Emphysema
<input type="checkbox"/> <input type="checkbox"/> Heart Attack/ Stroke	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Glaucoma
<input type="checkbox"/> <input type="checkbox"/> Hemophilia/ Abnormal Bleeding	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Rheumatoid
	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Heart Surgery/ Pacemaker
<input type="checkbox"/> <input type="checkbox"/> HIV & AIDS	<input type="checkbox"/> <input type="checkbox"/> Hospitalized for any Reason	<input type="checkbox"/> <input type="checkbox"/> High/ Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems
<input type="checkbox"/> <input type="checkbox"/> Severe/ Frequent Headaches	<input type="checkbox"/> <input type="checkbox"/> Shingles	<input type="checkbox"/> <input type="checkbox"/> Rheumatic/ Scarlet Fever
<input type="checkbox"/> <input type="checkbox"/> Ulcers/ Colitis	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease	<input type="checkbox"/> <input type="checkbox"/> Sinus/ Airway Problems
<input type="checkbox"/> <input type="checkbox"/> Allergy to Nickel	<input type="checkbox"/> <input type="checkbox"/> Has Menstruation started	<input type="checkbox"/> <input type="checkbox"/> Regular Radiation Exposure
<input type="checkbox"/> <input type="checkbox"/> Allergy to Latex	<input type="checkbox"/> <input type="checkbox"/> Clicking/ Popping of the Jaw	<input type="checkbox"/> <input type="checkbox"/> Mouth Breather
<input type="checkbox"/> <input type="checkbox"/> Pain of the Jaw/ Ear	<input type="checkbox"/> <input type="checkbox"/> Clench or Grind Teeth	<input type="checkbox"/> <input type="checkbox"/> Locking of Jaw Joint
<input type="checkbox"/> <input type="checkbox"/> Speech Problems/ Therapy	<input type="checkbox"/> <input type="checkbox"/> Finger/ Thumb Habit	<input type="checkbox"/> <input type="checkbox"/> Injury to Teeth/ Mouth
<input type="checkbox"/> <input type="checkbox"/> Allergies to medications (please list)		

Are you taking any medication? What? Why? _____

What are your main concerns regarding your teeth? _____

Have you had previous orthodontic treatment? When? _____

Have you had a previous orthodontic consultation? _____

When was your last dental exam/ cleaning? _____

What tooth extractions, if any, have you had? When? _____

Have you had periodontal (gum) treatment previously? When? _____

Parent or Guardian Signature _____ Date _____

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