MARK PREVITT DMD ORTHODONTICS

MEDICAL/DENTAL HISTORY FOR CHILD OR ADOLESCENT

DATE_____

NAME_____AGE___ DOB_____SEX_____
ADDRESS_____ HOME PHONE_____
DENTIST_____ PHYSICIAN_____
REFERRED BY_____

FATHER'S NAME_____ SS#_____
EMPLOYER _____ OCCUPATION_____
BUSINESS ADDRESS_____ BUSINESS PHONE_____
CELL PHONE _____ EMAIL ADDRESS_____

MOTHER'S NAME_____ SS# _____
EMPLOYER _____ OCCUPATION _____
BUSINESS ADDRESS_____ BUSINESS PHONE _____
CELL PHONE _____ EMAIL ADDRESS _____

FINANCIALLY-RESPONSIBLE PARTY_____
NAMES & AGES OF SIBLINGS _____
NAMES OF FAMILY MEMBERS TREATED IN THIS PRACTICE_____
DENTAL INSURANCE CO_____ ORTHODONTIC COVERAGE? Y N NOT SURE
HAS ORTHODONTIST BEEN CONSULTED PREVIOUSLY? Y N

PLEASE CHECK ANY OF THE FOLLOWING WHICH PATIENT HAS OR HAD

__DIABETES
__PNEUMONIA
__HEART CONDITION
__RHEUMATIC FEVER
__BONE DISORDERS
__HEPATITIS OR LIVER PROBLEM
__EATING DISORDER
__HIGH/LOW BLOOD PRESSURE
__AUTISM
__TOOTH GRINDING OR CLENCHING
__TUBERCULOSIS OR MONONUCLEOSIS
__ANEMIA OR BLOOD DISORDER
__EPILEPSY OR SEIZURES
__ASTHMA
__KIDNEY DISEASE
__IMMUNE DISORDERS
__THYROID/ENDOCRINE CONDITION
__SPEECH PROBLEMS
__THUMB, FINGER OR PACIFIER HABIT
__JAW PAIN OR CLICKING
__FACIAL OR DENTAL TRAUMA
__FAINTING OR DIZZINESS
__AIDS OR HIV+
__BIRTH DEFECTS/HEREDITARY CONDITION
__CANCER OR TUMOR
__EAR, NOSE, THROAT OR EYE CONDITION
__MENTAL DISORDER/BEHAVIORAL CONDITION
__SUBSTANCE ABUSE OR ALCOHOLISM
__FREQUENT HEADACHES

PLEASE ELABORATE IF ANY CHECKED ABOVE_____
CURRENT DRUGS OR MEDICATIONS_____
ALLERGIES OR DRUG SENSITIVITIES_____
HAS PATIENT REACHED PUBERTY? Y N
HAVE TONSILS OR ADENOIDS BEEN REMOVED? Y N
IN YOUR OWN WORDS, WHAT IS THE PROBLEM? _____
_____

SIGNATURE_____