Patient's Name ____ Med Hx – Under 18

Physician's Name ____

Date of last visit ____

Patient's current health is: Good Fair Poor

Allergic Reactions (circle)

Latex Aspirin Nickel Jewelry Ibuprofen Other ____________________

Frequently experience (circle)

Headaches Fainting Teeth Grinding Vomiting

Gagging TMJ Problems Other: ____________________

Diagnosed or Treated (circle)

Arthritis	Asthma	Seizures	Hearing Impaired	**Rheumatic Fever
Head Trauma	Diabetes	Anemia	Hepatitis	** Heart Murmur
Teeth Trauma	Sleep Apnea	HIV/Aids	Blood Pressure	**Joint Replacement

Does the patient require antibiotic pre-medication for dental treatment? Yes No

Girls: Has menstruation begun (to determine if the patient is in a growing phase)? Yes No When? ______________

Is the patient pregnant? Yes No

Medications (please list with the reason for taking the medication)

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Dental Information

Patient's Dentist ________________________________ Approx. Date of last visit ____________________

How often does the patient brush their teeth? __________________ How often do they floss? __________________

What is your main reason for coming to Carolina Family Orthodontics, and what would you like to change about your smile?

____

____

Has the patient seen another orthodontist about this concern? ____

Has the patient had any prior orthodontic treatment? ____

Does the patient have any missing teeth or extra teeth? ____

How did you hear about our office? _____ Referring Dentist _____ Friend, please give name ____________________
_____ Mailer _____ TV/Radio Ad _____ Sign _____ Facebook _____ Website/Google
_____ Other ____________________

I consent that to the best of my knowledge the above information is complete and correct.

____ ____________________

Signature (parent or guardian if patient is a minor) Date