Dr. Joseph Whitesides

PATIENT INFORMATION

Patient's Name: _____ Prefer to be called: _____

Birthday: ____/____/____ Age: _____ School: _____Grade: _____

Physician: _____ E-Mail: _____

Dentist: _____ Last Visit: _____/_____/_____

Medical History Form

Please answer all of the following:

Yes No Is the patient in good health? _____

Yes No Has the patient had any history of hay fever, rheumatic fever, high blood pressure, hepatitis, epilepsy, cerebral palsy, health trouble, allergies, diabetes, asthma, kidney, liver or blood disorders, AIDS or HIV infection, for which he or she has received treatment or medicine. If so, underline problems.

Yes No Has the patient had surgery? If so, please specify. _____

Yes No Has the patient had an unfavorable reaction to drugs, including antibiotics and local anesthetic solution? If so, please specify. _____

Yes No Is the patient presently taking any medications? If so, what? _____

Yes No Has the patient had any unfavorable experience in a dental or medical office? _____

Yes No Has the patient had any history of thumb sucking, finger sucking, lip biting, nail biting, speech problems? If so, underline problem.

Yes No Is the patient mentally or emotionally handicapped? _____

Yes No Is the patient a mouth breather? When awake? _____ While asleep? _____

Yes No Has the patient been informed of any missing or extra permanent teeth? _____

Yes No Has the patient experienced any problems or pain with the muscles or joints of the jaws? _____

Yes No Any baby or permanent teeth removed by your dentist? _____

Yes No Any traumatic injuries to the teeth, face or jaws? _____

Has the patient ever been examined by an orthodontist before? _____ When? _____

Has the patient ever worn braces or retainers? _____ Describe _____

Has any member of your family received orthodontic treatment: _____

Women – Are you pregnant? _____ Due date: _____

If under 18: Onset of puberty: (boys-voice change, girls-started menstruation) Yes_____ No _____

In your own words, what do you feel is the orthodontic problem : _____

Patient Information

Patient's Name: _____

Address: _____

Home/Cell Phone: _____

Responsible Party Information

Name: _____ Marital status: _____

Address: _____

Home phone: _____ Cell: _____ Work: _____

Birth date: _____ Social Security # _____ Relationship to patient: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Relationship to patient: _____

Employer: _____ Occupation: _____

Birth date: _____ Social Security # _____

Insurance Information

Policy Holders Name: _____ Social Security # _____DOB: _____

Insurance company: _____

Insurance company phone # _____ Group Number: _____

Policy Holders Employer: _____

Emergency Information

Name of nearest relative not living with you: _____

Complete address: _____

Phone #: _____ Relationship: _____

If the patient is a minor, it is necessary that a signed permission is obtained from a parent or guardian before any and all necessary dental service can be started and accomplished by the doctor. Authorization is hereby granted as such.

Signed: _____ Date: _____