embrace
your smile

PATIENT NAME [CHILD]

7684 6/17

LAST ____ FIRST ____ MIDDLE ____

D.O.B. ____ / ____ / ____   ☐ MALE   ☐ FEMALE

PREFERRED NAME: ____ **PHONE:** ____

ADDRESS: ____
STREET   CITY   STATE   ZIP

School: ____ Grade: ____
Patient's Dentist: ____ Last Visit: ____
Patient's Physician: ____ Last Visit: ____
Whom may we thank for referring you to us? ____
Do you plan to relocate out of the area in the near future? Y N If so, when? ____
Which office location is most convenient to you? ☐ Pensacola ☐ Pace ☐ Jay

Father's Name: ____ SSN: ____
Employer: ____ Business Phone: ____
Other phone number(s) **father** can be reached at: ____
Mother's Name: ____ SSN: ____
Employer: ____ Business Phone: ____
Other phone number(s) **mother** can be reached at: ____

Is the patient under any medical treatment now? Y N If so, what? ____
List any medications the patient is currently taking: ____
List any drug allergies/sensitivities: ____
List any history of serious illness, accident, surgery, or other condition: ____
List any injury/trauma the patient has had to his/her jaws: ____

HAS THE PATIENT HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N HEAD OR FACIAL INJURY
Y N TONSILLITIS
Y N HEPATITIS/LIVER DISEASE
Y N RHEUMATIC FEVER
Y N HIV/AIDS
Y N KIDNEY DISEASE
Y N ALLERGIES OR ASTHMA
Y N METAL ALLERGIES
Y N HEART MURMUR/PROBLEMS
Y N ARTHRITIS
Y N VENEREAL DISEASE
Y N EPILEPSY/SEIZURES
Y N BLEEDING PROBLEMS
Y N DIABETES
Y N EAR INFECTIONS
Y N CANCER/CHEMOTHERAPY
Y N HEARING DISORDER
Y N HIGH BLOOD PRESSURE
Y N EMOTIONAL PROBLEMS
Y N NERVOUS PROBLEMS
Y N ENDOCRINE PROBLEMS
Y N JAW JOINT PAIN (TMJ)

Has the patient ever sucked their thumb or finger(s)? Y N If so, until what age? ____
Have you been informed of any missing or extra permanent teeth? ____
Has an orthodontist been consulted previously or has the patient had previous orthodontic treatment?
Y N If so, by whom? ____
What part of the patient's orthodontic problem concerns you the most? ____

Additional information you feel would make the patient's experience with us more enjoyable: ____

The information I have given today is correct to the best of my knowledge. I understand that this information will be held in strictest confidence, and it is my responsibility to inform this office of any changes in the medical status of this patient.

____ PARENT'S SIGNATURE   ____ / ____ / ____ DATE

K. Glenn Brooks
DDS, MS, PA