

MEDICAL HISTORY

	YES	NO		YES	NO
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Involvement _____	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia _____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble _____	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever _____	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disorders _____	<input type="checkbox"/>	<input type="checkbox"/>	Fainting / Dizziness _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia _____	<input type="checkbox"/>	<input type="checkbox"/>	Liver Involvement _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
History of Joint Replaement _____	<input type="checkbox"/>	<input type="checkbox"/>	Current or past Phen fen use _____	<input type="checkbox"/>	<input type="checkbox"/>
			Latex Allergy _____	<input type="checkbox"/>	<input type="checkbox"/>

Have tonsils and adenoids been removed? YES NO At what age? _____

List any drugs or medications being taken: _____

List any allergies or drug sensitivities: _____

DENTAL HISTORY

	YES	NO
Have there been any injuries to the face, mouth or teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever sucked a thumb or fingers? Until what age? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have any speech problems? _____	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient a mouth breather? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you been informed of any missing or extra permanent teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has an orthodontist been consulted previously? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has any member of the family had orthodontic treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Date of last dental examination? _____		

OTHER INFORMATION

Patient's Physician: _____ Phone# _____ Last Visit: _____

Patient's Dentist: _____ Phone # _____ Last Visit: _____

Other Children in Family: Name _____ Age _____ Name _____ Age _____

Who may we thank for referring you? _____

Reason for seeking orthodontic care: _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his Staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to my medical or dental status, I will so inform this practice.

Please sign and fax to **949-472-8606**, email to **info@kimfamilyortho.com**, or bring to your next scheduled appointment.

Patient/Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____