Patient name _____ Age_____ Sex_____
Last first middle init.
Home Address_____ City_____ Zip_____

Telephone #_____S. S. #_____ Birth date_____ Physician_____

Patient's dentist_____ Referred by_____ Oral surgeon_____

Employed by_____ Occupation_____Work Phone #_____

Spouse's name_____ Spouse's Birth date_____ S. S. #_____

Spouse Employed by_____Occupation _____Phone # _____

Insurance company _____Subscriber's name_____

Nearest relative not in household, name and address_____

_____

MEDICAL HISTORY

Is the patient in good health? ___Yes ( ) No ( )
Does the patient have a history of major illness or allergies? (please list) _____

Check any of the following for which the patient has been treated:

Diabetes …….….( )	Tuberculosis ……...…...( )	Endocrine Problems …...…..…..( )
Pneumonia …….…….( )	Anemia ….……..…..…( )	Prolonged Bleeding ……...( )
Heart Trouble ……..…( )	Epilepsy …..……..…..( )	Fainting or dizziness ……..…...( )
Rheumatic fever …….( )	Asthma ….…..……..…( )	Nervous disorder…….…...…( )
Hepatitis ……..…( )	Kidney disorder ….……( )	Liver disorder …….…..…….( )
Bone disorder ……..…( )	HIV Positive……...….( )	STDS……. ……( )
Does the patient tend to have colds ( ), sore throats ( ), ear infections ( )		Blood Pressure ……..( )

List all medications being taken and reason_____

_____

DENTAL HISTORY

Has there been any injuries to the face, mouth, or teeth?……..……Yes ( ) No ( )
Has the patient ever sucked a thumb or finger?……..……..…… .Yes ( ) No ( )
Does the patient have any speech problems?…….…….…..… Yes ( ) No ( )
Is the patient a mouth breather?……...…Asleep Yes ( ) No ( )…….…...…..…Awake Yes ( ) No ( )
Have you been informed of missing or extra teeth?…….…….Yes ( ) No ( )
Has either parent had orthodontic treatment?…….…….....…Yes ( ) No ( )
Has an orthodontist been previously consulted?…….…..…..Yes ( ) No ( )
List any musical instruments played_____

I authorize Dr. Hastings to discuss treatment information with the following:
( ) Other medical or dental providers deemed necessary
( ) Insurance carriers
( ) The following individuals _____

_____ Date_____
Patient Signature