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

Phone #_____School_____ Grade_____ Birth date_____

Dentist_____ Referred by_____ Physician_____

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

Employed by_____ Occupation_____ Phone #_____

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

Employed by_____ Occupation_____ Phone #_____

Names and ages of other children in the family_____

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 ……..( )
Patient height_____ Weight_____ Has the patient reached puberty? Yes ( ) No ( )
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_____
Parent/Guardian Signature