

ACCOUNT NO. _____ Patient's Name _____ Preferred Name _____
 Birthdate _____ Age _____ Sex _____ School _____ Grade _____
 Patient's Dentist _____ Physician _____
 Mother's Name _____ Mother's SSN _____ Mother's Birthdate _____
 Home Address _____ Home Phone _____
 City/State/Zip _____ Work Phone _____
 Occupation _____ Employed By _____
 Father's Name _____ Father's SSN _____ Father's Birthdate _____
 Home Address _____ Home Phone _____
 _____ Work Phone _____
 Occupation _____ Employed By _____
 Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Widow(er) _____
 Name of any family members we have seen _____
 Names and Ages of Other Children in the family _____
 Person(s) responsible for Payment of Account _____
 Address and Relationship to Patient _____

HOW DID YOU HEAR ABOUT US?

INSURANCE COMMUNITY EVENT POST CARD MAILER
 WEBSITE VAL PAK CHAMBER OF COMMERCE
 REFFERAL (PLEASE INDICATE WHOM WE SHALL THANK): _____
 OTHER _____

MEDICAL HISTORY

Is the patient in good health? _____ Does the patient have any history of major illness? _____
 Please list (give dates) _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

<input type="checkbox"/> HEART TROUBLE	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> ATTENTION DEFICIT	<input type="checkbox"/> LIVER INVOLVMENT
<input type="checkbox"/> MITRAL VALVE PRO	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> HEPATITIS
<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> ENDOCRINE PROBLEMS	<input type="checkbox"/> BLOOD DISORDERS
<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> PROLONGED BLEEDING	<input type="checkbox"/> DIABETES
<input type="checkbox"/> PNEUMONIA	<input type="checkbox"/> FAINTING OR DIZZYNESS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> OTHER _____

Does patient have tendency to: Colds _____ Sore Throats _____ Ear Infections _____ Cold Sores _____
 Have tonsils and adenoids been removed? _____ What Age? _____ List any drugs or medications now being taken and reason. _____
 List any allergies or drug sensitivity _____
 Has the patient reached puberty: Girls-has she started menstruation _____ If so date of onset _____
 Boys-has his voice changed _____

DENTAL HISTORY

Date of last dental cleaning _____ Date of last X-rays _____
 Has the patient had a Panoramic/Panorex X-ray? **Y / N / Don't know** If yes, When? _____
 Have there been injuries to the face, mouth or teeth? **Y / N** If yes, describe and give date _____
 _____ Has the patient ever sucked a thumb or fingers? **Y / N** Age _____
 Any pain in or near the ears? **Y / N** Does the patient have any speech problems? **Y / N**
 Have you been informed of any missing or extra permanent teeth? **Y / N**
 Has an orthodontist been consulted previously? **Y / N** Has either parent had orthodontic treatment? **Y / N**
 List any musical instruments played _____
 Interests or hobbies _____
 Signature (parent or guardian's) _____ Date _____