EMERGENCY INFORMATION

Name And Number Of Nearest Relative Not Living With You To
Notify In Case Of Emergency_____
Physician's Name _____ Phone _____

MEDICAL HISTORY

Is The Patient In Good Health? _____ Yes _____ No
Explain:_____
Any Major Or Unusual Illness? _____ Yes _____ No
Explain:_____
Currently Being Treated By A Physician? _____ Yes _____ No
Explain _____
Currently Taking Medication? _____ Yes _____ No
List: _____
Allergies-List: _____
Drug Sensitivity-List: _____
Has The Patient Had Any Severe Head Or Face Injuries?_____Yes ____ No
Explain:_____
Has The Patient Had A History Of Thumb Or Finger Sucking?_____
Stopped? _____ When?_____
Has The Patient Previously Consulted An Orthodontist? _____Yes_____No
If Yes, When? _____
Has The Patient Had Any Orthodontic Treatment ? _____ Yes _____ No
If Yes, When? _____ Where? _____
Has Either Parent Had Orthodontic Treatment?-Mother?_____
Father? _____ When? _____

PLEASE CHECK YES OR NO TO THE FOLLOWING:

Yes	No		Yes	No	
____	___	Anemia	___	____	Tonsils Removed Age_____
____	___	Epilepsy	___	____	Scarlet Fever
____	___	Blood Disease	___	____	Adenoids Removed Age_____
____	___	Frequent Colds Or Flu	___	____	Heart Problem
____	___	Mouth Breathing	___	____	Prolonged Bleeding
____	___	Tonsilitis	___	____	Tuberculosis
____	___	Jaundice	___	____	Glaucoma
____	___	Adenitis	___	____	Diabetes
____	___	Rheumatic Fever	___	____	Hepatitis
____	___	Endocrine Problems	___	____	Herpes
____	___	Bone Disorders	___	____	Hiv/Aids Virus

This Form Was Completed By:

_____ _____
Signature Date