Today's date:	-		(please complete the front and i	back of	the form)
Name: Mr./Dr./Miss/Mrs./Ms.					
Marital Status: S M W D		Birth date			
Street Address:					
			Zip Code:		
			Carrier:		
E-mail:			Dentist:	150	
Emergency Contact:			Phone:		500
Billing Information: Are you re	spons	ible for th	is account/billing? Yes or No (please	circle o	one)
Social Security Number:			_		
Dental Insurance Information:	Emp	loyer:	Group #		
Insurance Company Name: _					
			t if there is a secondary insurance/or		party)
			Zip Code:		
			Alternate Phone:		
Birth date:		_ Social	Security Number:		
			Group #		
Insurance Company Name: _					
Dental History:					
Have you had previous orthodo	ontic t	reatment	? Yes or No (please circle one)		
			How often do you floss?		
Last time I saw a dentist was:		The rest	Last tooth cleaning:		
Please indicate if you have, ha	d or d	o any of th	he following by marking Yes or No		
	Yes	No		Yes	No
Bad breath			Jaw pain or tenderness		
Bleeding gums			Lip or cheek biting		
Missing teeth			Loose teeth	0	0
Burning sensation on tongue			Mouth breathing		
Chew on one side of mouth			Mouth pain		
Dry mouth			Pain around ears		0
Fingernail biting		0	Broken filings		
Food collection between teeth			Sensitivity to temperatures		
Grinding of teeth			Sensitivity while biting		
Gum swollen or tender			Smoker/tobacco chewer	0	0
Thumb or finger sucking			Sores, blisters or growths		over>

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describe:	seriou	15 111111111111111111111111111111111111	s of surgenes: (please i	riciade	ПОЗРІС	ilizacions) res di No 1	ı yes,	picas
Diago indicato by ma	rkina '	Voc or	No if any of the followi	ng ann	hv.			
Please indicate by ma			NO II ally of the followi				W	NI-
AID/HIV	Yes	No	Diabetes	Yes	No	Pacemaker	Yes	No
Anemia			Emphysema			Radiation treatment		
Arthritis/Rheumatism			Epilepsy			Sinus trouble		
Artificial heart valves			Fainting/dizziness			Skin rash		
Artificial Prosthesis			Headaches			Stroke		
Asthma			Heart murmur			Swollen feet/ankles		0
Blood disease			Heart problems			Swollen neck glands		
Cancer			Hepatitis type			Thyroid problems		
						Tonsillitis		
Chemotherapy			High blood pressure					
Circulatory Problems			Kidney disease			Tuberculosis Ulcer		
Congenital heart problems			Liver disease					
Facial ticks			Low blood pressure			Pregnant		
Cortisone treatments			Mitral valve prolapse			Psychiatric treatment		
Nama list any madisa	tion b	aind tal	en that would affect der	atal has	lth.			
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