Have there been any	seriou	s illnes	s or surgeries? (please i	nclude	hosnita	lizations) Vos or No. 1	fvoc	nlose
describe:			o or burgeries. (piedse i	ricidae	Поэрісс	inzacions) res or No 1	ıı yes,	pieas
Please indicate by ma	rking `	Yes or	No if any of the followi	ng app	ly:			-
	Yes	No		Yes	No		Yes	No
AID/HIV			Diabetes			Pacemaker		
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		
Blood disease			Heart problems			Swollen neck glands		
Cancer			Hepatitis type			Thyroid problems		
Chemotherapy			High blood pressure					
Circulatory Problems						Tonsillitis		
N5.0			Kidney disease			Tuberculosis		
Congenital heart problems			Liver disease			Ulcer		
Facial ticks			Low blood pressure			Pregnant		
Cortisone treatments			Mitral valve prolapse			Psychiatric treatment		
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Date: __

Patient/Parent signature:

Today's date:			(please complete	the fr	ont and	back	of form
Tell us about your child:							
Name:			Birth date				
			Zip Code:				
			:				
			Phone:				
			for this account/billing? Yes o				ne)
Name:						_	
Street Address:						_	
			Zip Code:				
			Cell #(
			(for appoint				
			Security Number:			20	
			Group				
		8 0-	dioup				_
Parent #2's Information: Are	you res	ponsible	e for this account/billing? Yes o	r No (p	lease o	ircle c	ine)
Name:						_	
Street Address:						_	
City:			Zip Code:				
			Cell #				
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Charles and the control of the contr			Il Security Number:			0113)	
Birth date:			And Color of the C				
			Group	#			-
Insurance Company Name: _			the state of the s				
Dental History:							
Previous orthodontic treatmen	nt? Yes	or No V	When was the last dental visit?				
How often does he/she brush	?		How often does he/she	floss?			
Please indicate if your child ha	as, had	or does	any of the following by marking	Yes	or No		
	Yes	No		12	Yes	No	
Bad breath		_	Jaw pain or tendernes		_		
Bleeding gums			Lip or cheek biting				
Missing teeth			Loose teeth				
Burning sensation on tongue			Mouth breathing				
Chew on one side of mouth			Mouth pain				
Dry mouth			Pain around ears				
Fingernail biting			Broken fillings				
Food collection between teeth			Sensitivity to tempera	ures			
			Sensitivity while biting				
Thumb or finger sucking			Smoker/tobacco chev				
Grinding teeth Gums swollen or tender			Sores, blisters or grow				Over>>
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