



Patient's Name (Nickname) _____ DOB ____/____/____ SSN _____

Responsible Party _____ Relationship to Patient _____ SSN _____

Address _____ City _____ State _____ Zip _____

Preferred Contact Phone # _____ Other #(s) _____

Email Address _____

Dental Insurance? Yes No Subscriber's Employer _____

Patient's School _____ Grade _____

Patient's Dentist _____ Date of Last Appointment _____

Patient's Physician _____ Date of Last Appointment _____

Referred By _____

Reason for consultation _____

Initial Examination Medical History

The purpose of this brief medical history form is to let our office know of any medical conditions that must be communicated prior to your (or your child's) initial oral exam.

Please list all medical conditions, illnesses or infectious diseases. **If no concerns, please circle → NONE.**

Please list all current drugs/medications. **If no concerns, please circle → NONE.**

Please list any drug allergies. **If none, please circle → NONE.**

- | | | | |
|---------------|---|---------------|---|
| Yes No | Have there been any injuries to the face, mouth or teeth? | | |
| Yes No | Heart murmur or valve concerns? | | |
| Yes No | Need for antibiotic pre-medication prior to dental procedures? | | |
| Yes No | Currently taking bisphosphonate medications (Fosamax, Boniva, Actonel, etc.)? | | |
| Yes No | Latex Allergy? | Yes No | Metal Allergy? |
| Yes No | Social Concerns Regarding Smile? | Yes No | Currently sucking thumb and/or fingers? |
| Yes No | Possibility of pregnancy? | Yes No | Suffer from sleep apnea? |

I hereby give my permission and/or consent to have Dr. David Freeman and/or his staff to contact my/my child's healthcare providers as necessary to coordinate my orthodontic care.

Signature of Responsible Party **Date** **Relationship to Patient**