THE GEORGIA
SCHOOL OF ORTHODONTICS

PATIENT HISTORY FORM

Today's date:	Consultation Appointment:	Time:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	DOB: / /	Gender: ❑ M ❑ F	Social Security#: - -
Preferred Name/Nickname:	School/Employment:	Email:	
Home Address:	City:	State:	ZIP Code:

WHO IS WITH THE CHILD TODAY

Name:	Relation:	Do you have legal custody of this child?	❑ Yes ❑ No

MOTHER'S INFORMATION

Name:		Home Phone Number:	
Employer:		Work Phone Number:	

FATHER'S INFORMATION

Name:		Home Phone Number:	
Employer:		Work Phone Number:	

RESPONSIBLE PARTY

Responsible Party Last Name:	Responsible Party First:	Middle:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

Home address:	City:	State:	ZIP Code:

DOB: / /	Social Security#: - -	What is the best way to reach you?	❑ Home ❑ Work	❑ Cell ❑ Email	❑ Daytime ❑ Evening	Email Address:	

What is the responsible party's relationship to the patient?:		Driver's License#:	State:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone #: ( )

DENTIST INFORMATION

Dentist Name:			
Address:	City:	State:	ZIP Code:
Phone: ( )	Date of Last Dental Visit:		

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REFERRAL SOURCE					
Whom may we thank for referring you?	❑ Dentist ❑ Patient	❑ Television ❑ Yellow Pages	❑ Insurance ❑ Radio	❑ Newspaper/Print ❑ Internet	❑ Other (Please specify)
Name of Referrer:					

DENTAL/MEDICAL HISTORY						
What is your main reason for visiting the orthodontist today?						
Are you currently experiencing any pain?	❑ Yes	❑ No	Your current dental health is:	❑ Good	❑ Fair	❑ Poor
Have you ever had a serious/difficult problem associated with previous dental work?	❑ Yes	❑ No				
Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)?	❑ Yes	❑ No				
Do you like your smile? ❑ Yes ❑ No	Do your gums bleed?	❑ Yes	❑ No	How many times a week do you floss?		
How many times a day do you brush?						
Physician Name:		Physician Phone:		Last Visit:		
Your current physical health is: ❑ Good ❑ Fair ❑ Poor	Are you taking any prescription drugs?	❑ Yes	❑ No	Drug and Dose:		
Are you currently under the care of a doctor?	❑ Yes	❑ No	Explain:			

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?											
Y	N	Prothesis	Y	N	Tuberculosis	Y	N	Convulsions/Epilepsy	Y	N	High/Low blood pressure
Y	N	Heart Attack	Y	N	Shingles	Y	N	Abnormal Bleeding	Y	N	Drug/Alcohol Abuse
Y	N	Cancer	Y	N	Fever blister	Y	N	Artificial Valves	Y	N	Blood Transfusion
Y	N	Diabetes	Y	N	Venereal disease	Y	N	Heart surgery/Pacemaker	Y	N	Anemia/Radiation Treatment
Y	N	Rheumatic Fever	Y	N	Ulcers/Colitis	Y	N	Any Stays in Hospital	Y	N	Glaucoma
Y	N	HIV+/AIDS	Y	N	Heart Murmur	Y	N	Kidney/Liver Problems	Y	N	Difficulty Breathing?
Y	N	Hemophilia	Y	N	Emphysema	Y	N	Mitral Valve Prolapse	Y	N	Scarlet Fever
Y	N	Asthma	Y	N	Sinus Problems	Y	N	Artificial bones/joints	Y	N	Other:
Y	N	Hepatitis	Y	N	Congenital Heart Defect	Y	N	Sever/Frequent headaches			

Are you allergic to any of the following?	Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Tetracycline	Y	N	Other:
	Y	N	Antibiotics	Y	N	Latex	Y	N	Penicillin			

FOR WOMEN ONLY:						
Are you pregnant?	❑ Yes	❑ No	Week #:	Are you taking birth control pills?	❑ Yes	❑ No

I understand the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.

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Signature