Ericka Sample D.D.S., P.A.

Specialist in Orthodontics for Children and Adults

Patient name: _____ Nickname: _____ Date: _____

Patient Address: _____ Phone: _____

Birth date: _____ Age: _____ Sex: _____ Dentist: _____

Primary Responsible Party: ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Name: _____ Cell#: _____

Address: _____ Home #: _____

Secondary Responsible Party: ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Name: _____ Cell# _____

Address: _____ Home #: _____

Child's parents are: ☐Married ☐Divorced ☐Separated ☐Mother deceased ☐Father deceased

If parents do not live together, with whom does the child live? _____ Is this the child's legal guardian? ☐Yes ☐ No

Who may we thank for referring you to our office? ☐Dentist ☐Friend (specify) _____

☐Internet ☐Other (specify) _____

Circle Yes or No for which the patient has or had a history of:

MEDICAL HISTORY								HABITS	
Aids	Y N	Cancer	Y N	Hepatitis	Y N	Nervous Disorders	Y N	Cheek biting	Y N
Allergies	Y N	Cold Sores	Y N	Herpes	Y N	Organ Transplant	Y N	Clenching teeth	Y N
Anemia	Y N	Diabetes	Y N	High Blood Pressure	Y N	Periodontal problems	Y N	Grinding teeth	Y N
Anorexia	Y N	Drug allergies	Y N	HIV positive	Y N	Polio	Y N	Lip biting	Y N
Arthritis	Y N	Endocrine problem	Y N	Immune problems	Y N	Pregnant	Y N	Mouth breathing	Y N
Asthma	Y N	Emotional disorders	Y N	Jaundice	Y N	Prolonged Bleeding	Y N	Nail biting	Y N
Blood Disorder	Y N	Epilepsy	Y N	Kidney problems	Y N	Scarlet Fever	Y N	Smoking	Y N
Blood Transfusion	Y N	Emphysema	Y N	Low Blood Pressure	Y N	Seizures	Y N	Speech problems	Y N
Bone Disorder	Y N	Fainting, Dizziness	Y N	Mononucleosis	Y N	Thyroid Disease	Y N	Thumb sucking	Y N
Bulimia	Y N	Heart conditions	Y N	Muscular disorders	Y N	Tuberculosis	Y N	Tongue thrust	Y N

List any allergies: _____

Current Medications? _____ Have you taken Bisphosphonates? _____

Any diseases or problems not mentioned above? _____

Females: Has Menstruation begun? _____ At what age? _____ Males: Has voice changed? _____ At what age? _____

Has the patient seen a General Dentist in the last year? _____ Date last seen: _____

Describe any clicking or discomfort near the ears? _____

Describe any face, mouth or teeth injuries? _____

Are there any missing or extra teeth? List: _____

Do gums bleed when brushed or flossed? _____ Have the Tonsils and adenoids been removed? _____

Does patient require Antibiotics before Dental work? _____ Medical Doctor: _____ Phone: _____

Emergency Contact Information **OTHER THAN PARENTS:**

Name: _____ Home #: _____ Cell #: _____

Signature: _____ Relationship To Patient: _____ Date: _____

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