ELLIS & LINDGREN

Never Underestimate the Power of a Smile

Date: ___________

General Information:

Patient Name: ______________________ DOB: ___/___/___ Age: ________

Address: ______________________ City: ______________ State: ______ Zip: ________

Phone Number (Home): ______________________ (Cell): ______________________

Email Address: ____

Referred By: ______________________ General Dentist: ______________________

Family Treated For Orthodontics By Our Office: ______________________

For Our Adolescent Patients:

Responsible Party: ____

Father's Name: ______________________ Employed By: ______________________

Position: ______________________ Phone Number (Work): ______________________

Mother's Name: ______________________ Employed By: ______________________

Position: ______________________ Phone Number (Work): ______________________

For Our Adult Patients

Employed By: ______________________ Position: ______________________

Phone Number (Work): ______________________

Spouse Name: ______________________ Employed By: ______________________ Work #: ____________

MEDICAL AND DENTAL HISTORY

Allergies: Are you allergic to anything including but not limited to latex, medications, nickel, etc.? **Y or N**

If yes (please list allergy): ____

Medications: Are you currently taking any medications (if yes please list): ______________________

Do you need to take antibiotics prior to dental treatment (premedication)? **Y or N**

Trauma: Have you ever had trauma to your head or neck that resulted in loss of consciousness, broken bones, or damage to the teeth (this includes chipped teeth, knocked out teeth – both lost and replanted, or intruded teeth). If so please explain: ____

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Female Patients Only: Are you currently or may you be pregnant? **Y or N** Has menstrual cycle begun? **Y or N**

Medical History: Have you ever had or do you no have any of the following?

	Yes	No
Heart Trouble		
Heart Attack (MI)		
Rheumatic Fever		
Heart Murmur		
High Blood Pressure		
Emphysema		
Asthma		
Tuberculosis		
Diabetes		
Ulcers		

	Yes	No
Stroke		
Epilepsy		
Arthritis		
Emotional Problems		
Psychiatric Treatment		
Skin Disease		
Lupus		
Cancer		
TMD / TMJ		
Liver Disease		

	Yes	No
AIDS		
HIV +		
Hepatitis B		
Hepatitis (other)		
Sickle Cell Anemia		
Bleeding Problems		
Other (Please List)		

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