WELCOME TO KATY ORTHODONTICS

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PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Dentist:_____

Employer: _____

Phone: (_____) _____

Date of Birth: _____

e-mail address : _____

Referred By: _____

Work #: _____ Cell #: _____

MEDICAL HISTORY

	Yes	No
Any Heart Disease:		
H.I.V. Positive of Aids:		
Any Venereal Disease:		
Any Bone Disease:		
High or Low Blood Pressure:		
Is Patient Under Medical Care:		
History of Fainting or Dizziness:		
Is the Patient in Good Health:		
Heart Murmur:		
Hepatitis:		
Are you pregnant:		

	Yes	No
Diabetes:		
Asthma or Hay Fever:		
Tuberculosis:		
Prolonged Bleeding:		
Any Epilepsy or Seizure Disorder:		
Is the Patient Allergic to Anything:		
If so, what:_____		
Are you aware of any other disease, condition or problem not listed above that we should know about:		

If Yes, What: _____

List Any Medications Currently Taking:_____

DENTAL HISTORY

Has the Patient Seen a General Dentist in the Last Year:	Yes	No
Any Pain, Clicking, or Discomfort In or Near the Ears:		
Has the Mouth, Face or Teeth Been Injured by a Accident:		
Frequent Headaches:		
Are you Aware of Any "Gum" Problems:		
Have the Patient's Tonsils or Adenoids Been Removed:		

	Yes	No
Thumb Sucking:		
Mouth Breathing:		
Finger Nail Biting:		
Tongue Thrusting:		
Clench/Grind Teeth:		

In Your Own Words What is the Orthodontic Problem:_____

_____

_____ _____

Date **Signature**