Please Fill Out	All That	Apply to	the	Patient
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Today's Date:				
Dental History				
Current dental health: Good Fair Poor				
General Dentist: When was the patient's last visit with their dentist?				
Tonsils and adenoids removed? Yes No Extra or missing permanent teeth? Yes No Tenderness in jaw or jaw joint? Yes No				
Has the patient had a previous a previous orthodontic evaluation? Yes No If yes, approximate date:				
Does the patient have any of the following habits?				
Clenching/grinding? Yes No Lip sucking/biting? Yes No Mouth breathing? Yes No Nursing bottle habits? Yes No Speech problems? Yes No Thumb/finger sucking? Yes No Tongue thrust? Yes No Nail/pen biting? Yes No Other oral habits:				
Medical History				
Current physical health: Good Fair Poor Is patient currently under treatment by No another healthcare professional? Yes				
Please check all of the following medical conditions that apply to the patient:				
Bleeding disorder/anemiaArtificial joints/valvesBlood transfusionCancer/chemotherapyCongenital heart defectDiabetesBreathing problemsDrug/alcohol abuseEmphysema/glaucomaEye/ear/nose/throat conditionEpilepsy/seizures/faintingFever blistersHeart attack/strokeHeart murmur/mitral valve prolapseHeart surgery/pacemakerHepatitis/liver problemsHigh/low blood pressureHIV+/AIDSHospitalizationsKidney problemsPsychiatric problemsRheumatic/scarlet feverSevere/frequent headachesSinus problemsSkeletal/bone problemsSkin disordersTuberculosis (TB)Ulcers/colitis				
Please describe any medical conditions:				
Has puberty begun? Yes No (For women only) Has menstruation begun? Yes No Year started:				
Any known drug allergies?				
Is the patient allergic to any of the following?				
List any medications the patient is currently taking (including over-the-counter medicines, vitamin and herbal supplements)				
Emergency Information				
In case of emergency, who should we call? Name: Phone #: Phone #:				
Relationship to patient: Physician: Phone #:				
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform Prairie Pointe Orthodontics of any changes in my medical status. I authorize Dr. Neuer's staff to perform any necessary orthodontic services that may be needed during diagnosis and treatment with my informed consent.				
Signature: Date:				