

W. NETTLES GREEN, D.M.D., M.S.

WELCOME TO OUR OFFICE

- Please Print -

DATE OF BIRTH _____

DATE _____

Patient's Name _____ Age _____ Sex: Male Female
First Middle Last

Name Patient Prefers to be Called _____ Telephone Number _____

Home Address _____ Zip Code _____

School _____ Grade _____

Patient's Hobbies or Interests _____

Patient's Dentist _____ Date of Last Visit _____

**IS THERE SOMEONE OTHER THAN YOUR DENTIST THAT WE MAY THANK FOR REFERRING YOU TO OUR OFFICE?
(FRIENDS, NEIGHBORS, PATIENTS, ETC.)** _____

Father's Name _____ Date of Birth _____

Employed by _____ Business Telephone _____

Father's Dental Insurance _____ Soc. Sec. No. _____

Insurance Address _____ Insurance Telephone _____

Mother's Name _____ Date of Birth _____

Employed by _____ Business Telephone _____

Mother's Dental Insurance _____ Soc. Sec. No. _____

Insurance Address _____ Insurance Telephone _____

Marital Status: Married Divorced Separated Single Widowed

Names and Ages of Other Children in Family _____

Please list any Family Members previously treated here _____

Is the patient under the care of a physician for a specific problem at the present time? Yes No Illness _____

List any medicines your child is currently taking _____

List any drug allergies _____

Is there a history of serious illness, accident or operation? _____

If so, list. _____ Physician/Pediatrician _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies or Asthma | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Head or Facial Injury | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Tonsilitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Endocrine Problems |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Adopted |

Has the patient reached puberty?

Girls: Has she started menstruation? Yes No If yes, Month/Year _____

Boys: Has his voice changed? Yes No

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth? _____ Yes No

Has the patient ever sucked a thumb or fingers? _____ Yes No

Until what age? _____

Has an orthodontist been consulted previously? _____ Yes No

Has the patient had any previous orthodontic treatment? _____ Yes No

If so, by whom? _____

Have you been informed of any missing or extra permanent teeth? _____ Yes No

What part of your child's orthodontic problem concerns you most? _____

Additional information which you feel would help make your child's association with us more enjoyable. _____

THANK YOU



Signature of Parent or Guardian