WELCOME from DR. SCHECTER and DR. ABRAHAM Date ________________

Patient's Name ________________________________ Age _____ Sex _____ Date of Birth ______________

Last First **Email** ______________________________

Residence Address _______________________ City ______________ Zip ______ Home Phone ____________

Referred by ________________________________ Cell Phone ____________

Patient's Dentist _________________________________ Physician ____________________________

Person Responsible for Account ____

If any: List name of Insurance Plan covering orthodontic treatment ______________________

Patient's Occupation: ____________________ Employed by _______________ Bus. Phone ____________

Business Address ____ Occupation ______________

If Patient married: Spouse's Name ____________ Employed by ________________ Bus. Phone ____________

Business Address ____ Occupation __________________

Single ______ Married ______ Divorced ______ Widowed ________

Names and ages of children in family ____

In case of emergency ____

Name Phone #

- MEDICAL HISTORY - (List where applicable)

Height ________ Weight ________ Is patient in good health? __________________ Yes ____ No ____

Does patient have any history of major illness? ______________________________ Yes ____ No ____

Check any of the following for which the patient has been treated:

Diabetes............❑	Tuberculosis...........❑	Endocrine Problems ....❑	
Anemia............ ❑	Heart Trouble......... ❑	Fainting or Dizziness.......... ❑	Pneumonia............. ❑
Asthma............ ❑	Rheumatic Fever ....❑	Emotional Problems........... ❑	Seizure Disorder .... ❑
Liver Problems ❑	Kidney Problems ....❑	AIDS or HIV Positive......... ❑	Prolonged Bleeding ❑

Has the patient ever been under the care of a physician for illness? ________________ Yes ____ No ____

Does patient have tendency to Colds _______ Sore throats _______ Ear Infections _______

Have tonsils and adenoids been removed? What age? __________ Yes ____ No ____

List any drug allergies or sensitivity: ____

Does patient bleed easily? _________ Have high fever with childhood diseases? ____________________

List any medications being taken ____

Are you pregnant? Yes ____ No ____

DENTAL HISTORY (underline & describe where applicable)

Any injuries to face, mouth, teeth? ____________ Date ____________ Yes ____ No ____

Does patient have any speech problems? ________________________ Yes ____ No ____

Is patient a mouth breather? While awake ________ While asleep ________ Yes ____ No ____

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

Has an orthodontist been consulted previously? _________________ Yes ____ No ____

List any musical instruments played with mouth or lips _____________________________________

Does patient vomit, gag or faint easily? ____________________________ Yes ____ No ____

Is patient aware of sores, lumps or irritations in the mouth? Yes ____ No ____

Does patient have a history of sores or irritations in the mouth? ____________ Yes ____ No ____

Any clicking, popping or pain of the jaw joint near ears? Right ____ Left ____

Date of last visit to a dentist? __________________ Date of last dental X-Rays ______________________

What would you like to gain by orthodontic treatment?____

____

Signature of Patient ***Date***

Consent for Orthodontic Exam & Treatment