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Policy or Member ID# on Card:						
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nsurance Co. Customer Service Phone # on Back of Card:						
Do you have dual coverage? Yes No If yes: Insured's Employer Insured's NameBirthdateSoc. Sec. #						
nsured's NameBirthdateSoc. Sec. #						
nsurance Company Group No						



Date___

Patient's	Name			Age	Birtho	date	Sex			
Grade		SchoolNames of brothers and sisters								
Plays musical instrument Yes No Type of musical instrument										
Whom m	nay we tha	nk for referring y	ou to our office?							
Previous YES	speech th NO ——		□ No Hobbies	<u>Medical</u> 's care?	<u>History</u>					
		Is patient taking	any pills, medications	s, or drugs?						
		Has patient ever	r had an unusual react	tion to medication?						
		Is patient allergi	c to anything?							
		Has patient had	any major surgery? F	or						
_		Are there any of	ve a chronic problem	s not mentioned ab		<u> </u>			Liver	
Has natie	ent been c		ted for any of the follo							
riao parie	Diabete		Bone Recession	Osteoporos	is	Epilepsy	Anemia			
	Endocri	ne Asthm	na Fainting	Cerebra	al palsy	Prolonged blee	ding			
YES	Heart t	rouble	Rheumatic fever	Tonsils <u>Dental I</u>	removed	Adenc	ids removed			
		Does patient bro Does the patien Does the patien Has the patient	w suck thumb or finge eathe predominantly t t clench or grind teeth t have pain or clicking had any severe head o been injured or chippo	ers? through the mouth n? at night upon closing the n or face injuries? W	? nouth? hen					
		Any noticeable of Has patient bee Have any teeth	difficulty in chewing o n informed of any ext (baby or permanent) I	r swallowing food? ra or missing teeth been removed by e	? xtraction? \	Why				
		Have you had an Would patient r Has patient even Does the patien	or of the family had oring previous orthodont mind wearing arbeen teased about a twant his/her teeth ser placed a retainer of	tic consultation or t Bands? ppearance of his/h traightened?	reatment? Headgeari er teeth?					