

Patient Information (Minor)

Patient Name		/
First Middle	Last	Nickname
D.O.B Age Ger	nder M 🗆 F 🗆 SSN	
Address		
City	State	Zip/Postal Code
Home Phone Number ()	_ Patient E-mail Address_	
General Dentist	Date Last Seen	
Who may we thank for referring you?		
Hobbies/Interests		
Attends School At		
Number of siblings Siblings		
Responsible Party / Guardian / Parent Info	rmation	
Mother's Name		SS#
Address (if different than patient's)		
City		
Phone Numbers Home ()	Cell ()	Work ()
Place of Employment		
Dental Insurance Company		Group#
Dad's Name	D.O.B	SS#
Address (if different than patient's)		
City	State	Zip/Postal Code
Phone Numbers Home ()	Cell ()	Work ()
Place of Employment	Occ	upation
Dental Insurance Company		Group#
Emergency Information		
Name of person to contact in case of emerge	ncy	
Address		
Phone () Relation		



Dental and Health History

Date

lame			D.O.B.	Gender M
First	Middle Last			
Dental Orthodontic Hist	ory	Yes	No	Additional Information
Thumb/ Finger sucking				
Tongue thrust				
Clenching/ grinding teeth				
Mouth breathing habit, snori	ng or difficulty in breathing			
	d primary (baby) or permanent teeth			
Difficulty in chewing or jaw of				
Had periodontal (gum) treati				
Teeth sensitive to hot or col				
	4			
Speech problems	and the literature is a fact to			
Supernumerary (extra) or co				
Had prior orthodontic exami				
Bleeding gums, bad taste or				
Periodontal "gum problems"				
* 1	muscles of the face or around the ears			
	or missing restorations (fillings)			
Taking any forms of fluoride				
Suffered injuries to your face	e, mouth, teeth or chin			
ADD/ ADHD AIDS/ HIV+	Primary Physician Phone Number ()			
Any operation	Last Visit		_	
Artificial Joints/	Current physical health is: ☐ God	od 🗆 Fair 🗆 Poor		
Valves	Explain			
Asthma	List current medications			
Cancer	List current medications			
Congenital Heart Disorder				
Convulsions	ls pre-med required for dental vis	Is pre-med required for dental visits? \square no \square yes		
Diabetes	Explain			
Epilepsy		Allergies to medications: ☐ no ☐ yes		
Handicaps/		Explain		
Disabilities				
Heart Murmur		Other allergies: \square yes \square no \square latex \square metals \square nickel \square plastic		
Hemophilia	other			
Hepatitis		Authorization		
Kidney Problems				
Liver Problems	I understand that the information			
Mitral Valve Prolapse	knowledge and that it will be held responsibility to inform Segal and	lver Orthodontics	of cha	naes in my child's or
Prosthetics	my own medical status. I authoriz			
Rheumatic Fever	necessary dental and/or orthodon	itic services on my	child	(if applicable) or
Scarlet Fever	myself as needed.			
Sickle Cell				
Disease				
Tuberculosis (TB)				

Patient Signature