ORTHODONTIC CONSULTANTS OF SAINT LOUIS

Patient Registration and Medical History

DIPLOMATES AMERICAN BOARD OF ORTHODONTICS

Date

PLEASE PRINT

Patient (Last, First, Middle Initial, Nickname) Date of Birth Sex M F

Address City State Zip

Home Phone Cell Phone Work Phone

Email Address ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Emergency Contact Name Phone

Other Family Members Seen Here Whom may we thank for referring you?

School Grade School Phone

Employer Occupation Work Phone

Father's/Guardian Name Dr./Mr.

Address (if different from above) City State Zip

Employer Occupation Work Phone

Mother's/Guardian Name Dr./Mrs./Ms.

Address (if different from above) City State Zip

Employer Occupation Work Phone

Who is Responsible for this account? Relationship to Patient

Medical and Dental History

Dentist's Name Date of last dental cleaning and x-rays: Physician's Name

Reason for consultation:

Has patient had an orthodontic evaluation in the last two years? Yes No

If yes, please specify:_____

Is medication required before dental procedures? Yes No

If yes, please specify:_____

Are you taking medication at this time? Yes No

If yes, please specify:_____

_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? Yes No

If yes, please specify:_____

_____

Are you under the care of a physician? Yes No

For what conditions?:_____

Is there anything else we should know about your medical history? Yes No

If yes, please specify:_____

Patient has a history of:

(PLEASE CHECK ALL THAT APPLY)

- ☐ Allergies
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bone Disorder
- ☐ Diabetes
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Latex Allergy
- ☐ Learning Disability
- ☐ Rheumatic Fever
- ☐ Traumatic Injury

Other:_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I authorize the release of dental and medical records relevant to dental treatment, or copies of such, to communicate/coordinate treatment.

_____

Signature

_____

Date