southoc Orthodontics
Where smiles start.

Chris Carter, DMD, MS

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Personal Information

Patients Name _____ Nickname _____

Address _____ City _____ Zip _____

Home Phone _____ Birthdate _____ Age _____

School _____ Hobbies _____

Who may we thank for referring you? _____

Parents Information

Father _____ Birthdate _____ Mother _____ Birthdate _____

Address _____ Address _____

City/Zip _____ City/Zip _____

Home Phone _____ Cell _____ Home Phone _____ Cell _____

Email _____ Email _____

Employer _____ Employer _____

Insurance Information

Person(s) Financially Responsible _____ Phone _____

Do you have dental insurance? _____ If Yes, Name of Insurance Company _____

Insured Social Security # _____ Insured Birthdate _____

Medical History

Dentist _____ Physician _____

☐YES ☐NO DIABETES	☐YES ☐NO ANEMIA	☐YES ☐NO PROLONGED BLEEDING
☐YES ☐NO PNEUMONIA	☐YES ☐NO EPILEPSY	☐YES ☐NO FAINTING/DIZZINESS
☐YES ☐NO HEART TROUBLE	☐YES ☐NO ASTHMA	☐YES ☐NO NERVOUS DISORDERS
☐YES ☐NO RHEUMATIC FEVER	☐YES ☐NO KIDNEY INVOLVEMENT	☐YES ☐NO LIVER INVOLVEMENT
☐YES ☐NO BONE DISORDERS	☐YES ☐NO TUBERCULOSIS	☐YES ☐NO ENDOCRINE PROBLEMS
☐YES ☐NO HEPATITIS	☐YES ☐NO GLAUCOMA	☐YES ☐NO HIV/AIDS

List any drugs or medications now being taken _____

History of Allergies or Drug Sensitivity _____

Dental History

Have there been any injuries to the face, mouth, or teeth? _____

Has patient ever sucked a thumb or fingers? Until what age? _____

Have you been informed of any missing or extra permanent teeth? _____

Is the patient a mouth breather? _____ Awake or Asleep? _____

Has an orthodontist been consulted previously? _____ Has the patient had any orthodontic treatment before? _____

If yes, when and where? _____

Date of last dental examination _____

What would you most like to have orthodontic treatment accomplish? _____

_____

Signature of parent/guardian _____ Date _____