Chad Fowler, D.D.S., M.S.D.
Diplomate, American Board of Orthodontics

Patient Information

LAST NAME	FIRST NAME	NICKNAME	SSN	SEX	DATE OF BIRTH	AGE

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE

SCHOOL (if student)	GRADE	EMPLOYER	BUSINESS PHONE	CELL PHONE

EMAIL	WHOM MAY WE THANK FOR RECOMMENDING US?	NAME OF DENTIST	

DENTAL INSURANCE CARRIER	INSURED'S NAME	POLICY/GROUP NO.	ID NO.

RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE	NAMES & AGES OF OTHER CHILDREN
1.	1.
2.	2.
3.	3.

NAME OF PERSONS AUTHORIZED TO BRING YOUR CHILD TO HIS/HER APPOINTMENTS AND RECEIVE INSTRUCTION AND/OR INFORMATION:

NAME	RELATIONSHIP TO PATIENT	PHONE
1.		
2.		

Parent Information (please complete if patient is a minor)

FATHER'S NAME _____

ADDRESS (if different from patient's) _____

_____

CITY _____ ST _____ ZIP_____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ EMAIL _____

DOB _____

MOTHER'S NAME _____

ADDRESS (if different from patient's) _____

_____

CITY _____ ST _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ EMAIL _____

DOB _____

Person Responsible For Account Information (please complete if different than parent)

NAME	RELATIONSHIP TO PATIENT	EMPLOYED BY/OCCUPATION		

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE	BUSINESS PHONE	CELL PHONE	EMAIL

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Medical History

Please check if patient has or has had				**Please check if patient has or has had**
[Y] [N]		[Y] [N]		[Y] [N]
[ ] [ ]	Joint swelling	[ ] [ ]	Tuberculosis	[ ] [ ] Any injuries to the face, mouth, teeth? (circle)
[ ] [ ]	Bone disorders	[ ] [ ]	Anemia	[ ] [ ] Thumb, finger, lip sucking? (circle)
[ ] [ ]	Heart trouble	[ ] [ ]	Epilepsy (convulsions)	[ ] [ ] More than average amount of decay/cavities?
[ ] [ ]	Mitral Valve Prolapse	[ ] [ ]	Prolonged bleeding	[ ] [ ] Any missing permanent teeth?
[ ] [ ]	Rheumatic trouble	[ ] [ ]	Faintness/dizziness	[ ] [ ] Any teeth removed by extraction?
[ ] [ ]	Thyroid problems	[ ] [ ]	Tonsils removed	[ ] [ ] Any difficulty in swallowing or chewing?
[ ] [ ]	Diabetes	[ ] [ ]	Adenoids removed	[ ] [ ] Any pain or clicking on opening mouth?
[ ] [ ]	Emotional problems	[ ] [ ]	Sore throats	[ ] [ ] Is patient adopted? At what age? _____
[ ] [ ]	Brain injury	[ ] [ ]	Tonsilitis	[ ] [ ] Does patient visit dentist regularly? Date of last visit _____
[ ] [ ]	Kidney or liver involvement	[ ] [ ]	Earaches	[ ] [ ] Has an orthodontist been consulted previously? If yes, please provide the reason for the consultation:
[ ] [ ]	Joint prosthesis	[ ] [ ]	Arthritis	

On items checked "Yes," please provide us with a more detailed description:

List any other serious illnesses:	
List any allergies:	
List drugs or medications now being taken:	
Is the patient currently under a physicians care? [ ] YES [ ] NO Reason:	
Name of physician Primary:	Other:
Approximately how much has patient grown in the past year?	Adolescent Female: Has menstruation begun? [ ] YES [ ] NO Date (month/year):
What would you like to accomplish with orthodontic treatment?	Patient's attitude toward orthodontic treatment (circle one) Motivated Will cooperate Not motivated

I have read and I understand the above questions. I will not hold Dr. Fowler or his staff responsible for any errors or omissions that I have made in the completion of this form.

I understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes to this history record or medical/dental status.

I agree to allow Dr. Fowler and his staff to discuss treatment with the parents/legal guardians/the financially responsible party and the patient's doctor/dentist.

_____ _____

SIGNATURE OF PATIENT/PARENT OR GUARDIAN IF PATIENT IS A MINOR **DATE**