

ACQUAINTANCE INFORMATION

Patient's Full Name _____

Nickname _____ Sex _____ Age _____ Birth date _____

Address _____ City _____ Zip _____

Home Phone Number _____ Email _____

School _____ Grade _____

Special Interests _____

Who may we thank for referring you to our office? _____

Patient's Dentist _____ Physician _____

Date of last dental check up _____ Any dental work needed? _____

FAMILY INFORMATION

Father's Name _____ Business Phone _____ Ext _____

Social Security No. _____ Birth date _____ Cell Phone _____

Employer _____ Occupation _____

If not the same as the patient, please include: Home telephone _____

Home address _____

Mother's Name _____ Business Phone _____ Ext _____

Social Security Number _____ Birth date _____ Cell Phone _____

Employer _____ Occupation _____

If not the same as the patient, please include: Home telephone _____

Home address _____

Brother(s) & Sister(s), ages _____

Any family members with previous orthodontic treatment? _____

Person responsible for patient's account _____

If not the same as patient, please include:

Home address _____ Home Phone _____

How long at the current address? _____ Buying _____ Renting _____

Name of orthodontic insurance plan, if any _____

>>> PLEASE COMPLETE BOTH SIDES <<<

GENERAL HEALTH INFORMATION

Present Health: Excellent Good Fair Poor

Please check any medical conditions that apply, either past or present:

- | | | |
|--------------------------|-----------------------------|---|
| Heart trouble or murmurs | Head injuries | History of TB disease |
| Congenital heart lesions | Epilepsy | Any kind of lingering fever |
| Rheumatic fever | Drug dependency | Bloody specks in your phlegm |
| Bleeding problems | Hepatitis | Night sweats |
| Blood disorders | HIV Positive (AIDS Virus) | Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) |
| Diabetes | Kidney or Liver involvement | Recent weight loss (not associated with a weight loss program) |
| Asthma | Latex sensitivity | |
| Pain in jaw joints | Chronic sinusitis | |

Has the diet pill known as fen-phen or Redux ever been taken? Yes No

Any medical condition currently being treated? _____

Any known allergies or drug reactions? Penicillin Codeine Sulfa Drugs Aspirin Hay Fever Latex
Other _____

Any sensitivity (allergy) to metals, certain jewelry, etc.? Yes No _____

Any previous injuries to the face or teeth? Yes No _____

Is there any other medical or dental history or problem that you feel should be brought to the doctor's attention? Yes No
(If yes, please explain) _____

Signed _____ Date _____

Thank you for your cooperation in supplying the above information which will remain confidential.

ARTHUR L. KOBAL, D.D.S.