Patient Medical History

Physician____________________________ **Office Phone** _______________ **Date of Last Exam**____________

	YES	NO
1. Are you under medical treatment now?	O	O
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain________________ ______________________________	O	O
3. [illegible] ______________________________		
4. [illegible]		
5. [illegible]		
6. [illegible]		
7. [illegible]		

8. Are you allergic to or have you had any reactions to the following:

	YES	NO
Local Anesthetics (eg. Novocaine)	O	O
Penicillin or any other Antibiotics	O	O
Sulfa Drugs	O	O
Barbitura[illegible]		
[illegible]		
[illegible]		
[illegible]		
[illegible]		
[illegible]		
[illegible] ____________________________		

9. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible] __________________________________ **[illegible]** ____________

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]
7. [illegible]

8. [illegible]
9. [illegible]
10. [illegible]
11. [illegible]
12. [illegible]
13. [illegible]
14. [illegible] __________
15. [illegible] __________ ______________________________

[illegible]

[illegible] during the period of such orthodontic care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I understand that my dental insurace carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. ____ ____________________

Signature of Patient (or parent if minor) Date