Welcome to Dr. Lennard's office! Our goal is to make your visit to our office pleasant and educational. The information you give us on this form will be helpful for that purpose.

Date__________
Patient's name__________________ Nickname________ Sex________ Birth Date________ Age________
Street address__________________ City____________ Zip________ Home phone (___)____________
School______________ Grade______ Interests/Sports/Hobbies ______________________________

Father's (or husband's) name ____________________ SS#______________ Birth Date__________
Address/phone (if different from above) ____
____
Employed by____________________ Occupation__________ Business phone (___)___________
Business address ____________________________________ Cell phone (   ) ________________
Dental Insurance ____________________________________ Group No. ___________________

Mother's (or wife's) name ______________________ SS#______________ Birth Date__________
Address/phone (if different from above)____
____
Employed by____________________ Occupation__________ Business phone (___)___________
Business address____________________________________ Cell phone (   ) ________________
Dental Insurance____________________________________ Group No.____________________

Siblings' names and ages____
Referred by____
Dentist ____ Physician __________________

For office use

Chief Concern____
Diagnosis____
____
____
____
____
____

Treatment____
____
____
____

Est. Treatment Time_______________ Phase I ____________________ Phase II ____________________
Fee Estimate ____________________ Phase I ____________________ Phase II ____________________

Date	Treatment	Next Appt.

DENTAL HISTORY

Y N Does patient see dentist regularly?
Date of last appointment___________

Y N Fluoride treatment in dental office?

Y N Fluoride drops or pills or fluoridated water?

Y N Has patient sucked thumb or fingers?
Until what age?_______________

Y N Has patient used pacifier?

Y N Is patient a mouth breather?

Y N Does patient clench or grind teeth?

Y N Speech problems or speech therapy?

Y N Difficulty chewing or swallowing?

Y N Were any teeth removed by extraction?
Explain___________________

Y N Has patient been informed of having missing or extra permanent teeth?

Y N Pain, clicking or popping when opening or closing mouth?

Y N Severe injuries to head or face?

Y N Head or neck pain?

Y N TMJ problems?

Y N Orthodontic treatment in the past?

Y N Other orthodontic consultations?

Y N Have any family members had orthodontic treatment? Who?___________

Y N Is patient adopted? At what age?_____

Y N Are you aware that some appointments will infringe on school/work time?

What concerns does the patient have about the appearance and/or function of his/her teeth?_____________________

____

MEDICAL HISTORY

Is patient currently under care of physician?
If yes, for what?________________

Please rate patient's medical health.
Good Fair Poor

Y N Is patient taking prescription drugs?
If yes, please list___________

____

Y N Is patient allergic to any drugs?
If yes, please list___________

____

Y N Does patient need to be pre-medicated before dental treatment? Explain____

____

Y N Has patient had adenoids or tonsils removed?

Y N Other operations or hospitalizations?
If yes, please describe___________

____

____

____

Has the patient ever had any of the following medical conditions or problems? If yes, please circle:

Heart Murmur	Hemophilia
Heart problems of any kind	Endocrine/growth problems
Rheumatic fever	Diabetes
Fainting/dizziness	HIV+/AIDS
Convulsions/epilepsy	Hepatitis
Hyperactivity	Allergies
Arthritis	Asthma

Please describe any other medical conditions not mentioned above___________________

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The information I have given is correct to the best of my knowledge and I understand that it will be held in the strictest of confidence. I also understand that I will be assisted with insurance claims to obtain maximum benefits, but that I am directly responsible for payment for all services rendered by Ian P. Lennard, DDS, MS.

Signature of patient, parent or guardian_______________________Date__________