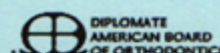


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Name _____ SS # _____ Date _____
Address _____ City _____ State _____ Zip Code _____
Date of Birth _____ Age _____ Sex (circle) Male Female
Home Phone # _____ Cell Phone # _____
E-mail address _____
Present Employer _____ Occupation _____ Work Phone # _____
In case of emergency, whom should we contact first? _____ Phone # _____
Family Dentist _____ Date of last visit _____
Whom may we thank for referring you? _____

MEDICAL HISTORY

NO YES HAVE YOU EVER HAD:

- ____ Any falls, accidents or operations of the mouth or jaws?
____ Rheumatic fever, heart murmur, congenital heart disease or endocarditis?
____ Heart trouble, heart attack, stroke, pacemaker or prosthetic (artificial) heart valve?
____ Any artificial bones or joints (prostheses) implanted?
____ Cold sores or fever blisters?
____ Hepatitis, jaundice, liver disease or tuberculosis?
____ Venereal disease, gonorrhea, syphilis, or herpes?
____ AIDS or positive antibody test to HIV, HTLV-III?
____ Do you bleed excessively after you are cut?
____ Allergic to Penicillin, aspirin or any other medications?
____ Allergic to latex?
____ Seizures or convulsions?
____ Psychiatric therapy?
____ Cleft Lip/Palate or arthritis?
____ Diabetes?
____ Do you smoke or chew tobacco?
____ Women: Are you pregnant or anticipating pregnancy in the near future?
____ Women: Are you taking oral contraceptives?
____ Do you take any medications (e.g. Fosamax or Boniva)? If yes, please list each medication and why you are taking it? _____
____ Are you presently under the care of a physician for anything besides routine check-ups?
____ Do you have any other medical conditions which you want to make us aware of? _____
____ Periodontal Disease?
____ Treatment for problems of your jaw joint (TMJ) or for facial muscle spasms?
____ Tonsils or adenoids removed?
____ Any finger sucking habits?
____ Previous orthodontic consultation?
____ Previous orthodontic treatment?
____ Why did you come to the orthodontist today? Please answer below.

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE, I WILL INFORM DR. SLUTSKY AT MY NEXT APPOINTMENT.

SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY: DOCTOR'S INITIALS AND DATE: