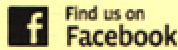
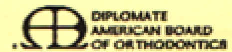


Harold Slutsky, D.M.D., P.C.
ORTHODONTIST



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Patient's Name ______________________ Date ______________
Address ______________ City ______________ State ________ Zip Code ____________
Patient's Date of Birth ______________ Age ________ Sex ________ Home Phone # ______________
E-mail address ______________________
Father's Name ______________ Home Phone # ______________ Cell Phone # ______________
Father's Address (if different than above) ______________________
Father's e-mail address ______________________
Mother's Name ______________ Home Phone # ______________ Cell Phone # ______________
Mother's address (if different than above) ______________________
Mother's e-mail address ______________________
With whom does patient live? ______________________
In case of emergency, whom should we contact first? ______________ Phone # ______________
Name of School ______________ Grade ________ Hobbies/Activities ______________
Number of brothers and sisters ________ Family Dentist ______________ Date of last visit ______________
Whom may we thank for referring you? ______________________

MEDICAL HISTORY

NO	YES	HAS YOUR CHILD 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?
___	___	Does your child bleed excessively after they're cut?
___	___	Allergic to Penicillin, aspirin or any other medications?
___	___	Allergic to latex?
___	___	Seizures or convulsions?
___	___	Psychiatric therapy?
___	___	Cleft Lip/Palate or arthritis?
___	___	Diabetes?
___	___	Does your child smoke or chew tobacco?
___	___	Women: Is your child pregnant or anticipating pregnancy in the near future?
___	___	Women: Is your child taking oral contraceptives?
___	___	Does your child take any medications? If yes, please list each medication and why each is being taken? ______________________ ______________________
___	___	Is your child presently under the care of a physician for anything besides routine check-ups?
___	___	Does your child 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 your child come to the orthodontist today? Please answer below. ______________________

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

SIGNATURE ______________________ DATE ______________

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