

**A SMILE BY DESIGN**  
**DR. MICHAEL L. FLETCHER, D.D.S., M.S.**  
*Specialist in Orthodontics*  
**NEW PATIENT INFORMATION**

**CHILD PATIENT**

Name: \_\_\_\_\_

*Last*

*First*

Nickname: \_\_\_\_\_

*Male*

*Female*

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

School \_\_\_\_\_ Grade: \_\_\_\_\_

List any musical instruments played: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Sports: \_\_\_\_\_

Who is accompanying patient today? \_\_\_\_\_

*Name & Relationship*

List brothers/sisters with birthdates \_\_\_\_\_

General Dentist: \_\_\_\_\_ Last visit date: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**Parent Information**

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Occupation: \_\_\_\_\_

Email: \_\_\_\_\_

**Person Responsible for Account**

Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

SS No. \_\_\_\_\_

**(Continue to page 2)**

# Medical History

Please check if the patient has or has had any of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> Heart trouble               | <input type="checkbox"/> Bone/joint disorders                           |
| <input type="checkbox"/> Heart murmur/heart defect   | <input type="checkbox"/> Osteoporosis or Bisphosphonate use             |
| <input type="checkbox"/> Artificial valves/pacemaker | <input type="checkbox"/> Emotional problems                             |
| <input type="checkbox"/> Rheumatic fever             | <input type="checkbox"/> Epilepsy/seizures                              |
| <input type="checkbox"/> HIV+ / AIDS                 | <input type="checkbox"/> Neurologic problems                            |
| <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Sinus problems                                 |
| <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Tonsils/adenoids removed                       |
| <input type="checkbox"/> Abnormal bleeding           | <input type="checkbox"/> Cancer   |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Use of cigarettes, cigars or smokeless tobacco |
| <input type="checkbox"/> Thyroid problems            | <input type="checkbox"/> Severe/frequent headaches                      |
| <input type="checkbox"/> Kidney or liver problems    | <input type="checkbox"/> Birth defects                                  |
| <input type="checkbox"/> Asthma/difficulty breathing | <input type="checkbox"/> Adopted  |

Is the Patient currently under the care of a physician? \_\_\_\_\_

Physician's name: \_\_\_\_\_

List drugs or medications now being taken: \_\_\_\_\_

List any serious illnesses or operations: \_\_\_\_\_

List any allergies: \_\_\_\_\_

# Dental History

Please check box if the patient has or has had any of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Any injuries to face, mouth or teeth |   |
| <input type="checkbox"/> Thumb/ finger sucking                |   |
| <input type="checkbox"/> Mouth breather                       | Does patient brush his/her teeth daily?    Yes    No                |
| <input type="checkbox"/> Any missing permanent teeth          | Does patient floss his/her teeth daily?    Yes    No                |
| <input type="checkbox"/> Any extra permanent teeth            |   |
| <input type="checkbox"/> Teeth removed by extraction          | What would you like to have orthodontic treatment accomplish? _____ |
| <input type="checkbox"/> Tongue thrusting problem             | _____   |
| <input type="checkbox"/> Speech problems                      |   |
| <input type="checkbox"/> Jaw joint problems                   |   |
| <input type="checkbox"/> Clenching or grinding teeth          | Has an orthodontist been consulted previously? _____                |
| <input type="checkbox"/> Bleeding gums/gum recession          | Reason: _____   |

*I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.*

*I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.*

---

Signature

Date