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_____
_____
_____

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_____