6501 TRANSIT ROAD || EAST AMHERST, NY 14051 || P 716-689-0313 || F 716-689-0314 || W LBortho.com

## PATIENT'S GENERAL HISTORY

The following information is necessary to aid us in the evaluation and treatment of you or your child.

Name:________________________________________
Age:________________________________________
Date of birth:____________________________________
Sex:________________________________________
Address:______________________________________
Phone:_______________________________________
Financially responsible person:__________________________
Billing address:__________________________________
Mother's name:__________________________________
Father's name:__________________________________
Dental Health insurance:_____________________________
Social security number:_____________________________
How did you hear about our office:________________________
Physician or pediatrician:____________________________
General dentist:__________________________________

## MEDICAL HISTORY (please circle all that apply)

| | | |
|---|---|---|
| Is ____________________ in good health? | Yes | No |
| Does he/she have regular medical examinations? | Yes | No |
| Is he/she taking any medications at the present time? | Yes | No |

If yes, please specify:____________________________________

________________________________________________________

| | | |
|---|---|---|
| Has he/she ever had an unfavorable reaction to a drug or medicine? | Yes | No |
| Has he/she been hospitalized in the last year? | Yes | No |
| Is he/she taking fluoride tablets or drops? | Yes | No |

Does ____________________ have a history of:

| | | |
|---|---|---|
| Heart disorder | Yes | No |
| Rheumatic fever | Yes | No |
| Diabetes | Yes | No |
| Kidney disorder | Yes | No |
| Epilepsy | Yes | No |
| Bleeding disorder | Yes | No |
| Allergies | Yes | No |
| Liver disorder | Yes | No |
| Asthma | Yes | No |
| Sexually transmitted disease | Yes | No |
| Mental health problems | Yes | No |
| Does he/she have poor coordination<br>Or problems with hearing, vision or speech? | Yes | No |