WELCOME TO OUR OFFICE!

Michael L. Mizell, D.D.S.

Specialist in Orthodontics

Date _____

PATIENT INFORMATION

Name: _____ _____ Home Phone (_____) _____
Called Name

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Birthday: _____ Age: _____

Dentist: _____ Referred By: _____

Employer: _____ Work #: _____ Cell #: _____

In Case of Emergency, Call: _____

MEDICAL

	YES	NO
Any Heart Disease:		
H.I.V. Positive:		
Any Venereal Disease:		
Any Bone Disease:		
Any High or Low Blood Pressure:		
Is Patient Under Medical Care:		
A History of Fainting or Dizziness:		
Is the Patient in Good Health:		
Heart Murmur:		
Hepatitis:		

	YES	NO
Diabetes:		
Asthma or Hay Fever:		
Tuberculosis:		
Prolonged Bleeding:		
Any Seizure Disorder:		
Is the Patient Allergic to Anything:		
What: _____		
Are you aware of any other disease, condition, or problem not listed above that we should know about:		
If Yes, What: _____		

List Any Medications Currently Taking: _____

_____

DENTAL HISTORY

	YES	NO
Has the Patient Seen a General Dentist in the Last Year:		
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:		
Frequent Headaches:		
Are You Aware of Any "Gum" Problems:		
Have the Patient's Tonsils or Adenoids Been Removed:		

	YES	NO
Thumb Sucking:		
Mouth Breathing:		
Finger Nail Biting:		
Tongue Thrusting:		
Clench/Grind Teeth:		
JAW JOINTS		
Pain/Discomfort		
Popping/Clicking		

In Your Own Words What is the Orthodontic Problem: _____

_____

Date _____ Signature _____