WELCOME TO OUR OFFICE!

Michael L. Mizell, D.D.S.

Specialist in Orthodontics

Date _____

PATIENT INFORMATION

Name: _____ _____ Phone H. (_____) _____
First Middle Last Called Name

Address: _____ Email: _____ Birthday: _____

City: _____ State: _____ Zip: _____ Age: _____ Sex: ☐ M ☐ F

Dentist: _____ Referred By: _____ School: _____ Grade: _____

PARENTS INFORMATION

FATHER

Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Cell: _____

Email: _____

MOTHER

Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Cell: _____

Email: _____

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:		
TMJ: ☐ Pain R L		
☐ Clicking/Popping R L		
☐ Discomfort R L		

In Your Own Words What is the Orthodontic Problem: _____

_____

Date _____ Parent Signature _____