Dr. Douglas J. Klein
D.D.S., M.S.D., P.C.
Diplomate American Board of Orthodontics
Asst. Professor, Department of Orthodontics, OHSU

DATE________________________

PATIENT'S NAME____ AGE__________ SEX__________
Last First Middle

ADDRESS____ CITY__________________ ZIP__________ PHONE________________
EMPLOYER ____ OCCUPATION________________________ PHONE________________
BIRTHDATE: MO________ DAY________ YR_________ PATIENT'S DENTIST ____
REFERRED BY ____________________________________ PATIENT'S PHYSICIAN ______________________________________

FAMILY INFORMATION (minors only)

FATHER____
Name Address City Zip Phone

MOTHER ____
Name Address City Zip Phone

❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED

DO YOU HAVE ORTHODONTIC INSURANCE? ❑ YES ❑ NO

PERSON RESPONSIBLE FOR ACCOUNT: NAME____

ADDRESS (if different from above)____

CITY________________________________ ZIP__________ PHONE______________________ (H) ________________________ (W)

MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH? ❑ YES ❑ NO

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

- ❑ Diabetes
- ❑ Pneumonia
- ❑ Heart Disease
- ❑ Rheumatic Fever
- ❑ Bone Disorders
- ❑ Glaucoma
- ❑ Tuberculosis
- ❑ Anemia
- ❑ Epilepsy
- ❑ Asthma
- ❑ Kidney Disease
- ❑ Hepatitis
- ❑ Endocrine Problems
- ❑ Prolonged Bleeding
- ❑ Fainting or Dizziness
- ❑ Nervous Disorders
- ❑ Liver Disease
- ❑ Other

Does patient have tendency to ❑ Colds ❑ Sore Throats ❑ Ear Infections

Have tonsils and adenoids been removed? What age:________________________ ❑ YES ❑ NO

List any drugs or medications now being taken. ____

Have you taken any medications for routine dental treatment? ❑ YES ❑ NO

____

List any allergies or drug sensitivity. ____

Has the patient reached puberty? (Not applicable for adults.)

Girls: Has she started menstruation? ❑ YES ❑ NO

Boys: Has his voice changed? ❑ YES ❑ NO

Height __________ Weight __________

Approximate date of last dental examination ____

Have there been any injuries to the face, mouth or teeth? ❑ YES ❑ NO

Has the patient ever sucked a thumb or fingers? Until what age? ❑ YES ❑ NO Age__________

Does the patient have any speech problems? ❑ YES ❑ NO

Reason for consultation____

Parent/Guardian/Patient Signature____ Date___________________