



## PRITCHETT ORTHODONTICS

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Patient #	Appointment Date & Time		
Name	Nickname	Sex	
Birthdate	Age	SS#	
Address			
City	State	Zip	Home Phone
Dentist	Physician		
How did you hear about our office?			
What questions would you like answered today by Dr. Pritchett?			

### COMPLETE FOR A CHILD PATIENT

School	Grade	Musical Instrument		
Sports	Hobbies/Interests			
Father's Name	Home Phone	Work Phone		
Address	City	State	Zip	
Father's SS#	Employer			
Mother's Name	Home Phone	Work Phone		
Address	City	State	Zip	
Mother's SS#	Employer			

### COMPLETE FOR AN ADULT PATIENT

Your Employer	Work Phone		
Spouse's Name	Employer	Work Phone	
Spouse's SS#			

### DENTAL INSURANCE INFORMATION (Please use information from your insurance card to complete this section)

Primary	Secondary		
Ins. Co.	Ins. Co.		
Address	Address		
City/St./Zip	City/St./Zip		
Phone#	Phone#		
Insured	Insured		
SS#	DOB	SS#	DOB
Group#	Group#		
Employer	Employer		
Person(s) responsible for payment & relationship to patient			

## PATIENT HISTORY

Patient's Height

Weight

Father's Height

Mother's Height

In your own words, what is the problem?

Does anyone else in the family have a similar problem?

If so, who?

Names of other family members previously examined in this office:

Date of last cleaning?

Have you ever had any serious problems associated with previous dental treatment?

If so, please explain:

## HEALTH HISTORY

Has the patient had any of the following:

• Baby teeth removed by dentist	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Major fall or accident involving head, face or teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Discomfort with bite	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Habits such as nail biting, thumbsucking, lip biting	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Tuberculosis or lung disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Speech problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Artificial joint	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Difficulty opening mouth	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Abnormal blood pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Noises or discomfort in/or around jaw joint	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Epilepsy, seizures, convulsions	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Jaw locking or getting stuck	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Rheumatic fever, heart murmur or other heart problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Clenches jaw muscles	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Heart surgery, heart pacemaker, mitral valve prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Grinds teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Frequent headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	• HIV positive/AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Sinus trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Hospitalized overnight	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Difficulty breathing through the nose (awake and/or asleep)	Yes <input type="checkbox"/> No <input type="checkbox"/>	• Taking any medications	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Cold sores	Yes <input type="checkbox"/> No <input type="checkbox"/>	If so, what?	
• Drug allergies/Penicillin, Latex, other	Yes <input type="checkbox"/> No <input type="checkbox"/>	• If female, are you pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Hay fever, asthma or other allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Please add anything you feel is important: \_\_\_\_\_

Signature/Date \_\_\_\_\_ Date Reviewed/Initials \_\_\_\_\_