JOHN B. WHITLEY, JR., D.D.S.

Practice Limited to Orthodontics and Dentofacial Orthopedics
***Member* AMERICAN ASSOCIATION OF ORTHODONTISTS**

ORTHODONTIC PATIENT INFORMATION

Date ________________ Family Dentist ________________________ Referred by ____________________

PATIENT

Name ____ ____________________
First Middle Last Nickname

Age __________ Birthdate ______________________________________ Sex __________
Month Day Year

Address ____ Phone ______________
Street City Zip

School ____ Grade __________

PARENTS or GUARDIAN

Mr. Dr.
Mrs. Ms. ____
(Circle)

❑ SINGLE
❑ MARRIED
❑ SEPARATED
❑ DIVORCED

FATHER'S

First Name ________________________________ SS# ________________
Employed by ________________________________ Position ________________
Bus. Address ________________________________ Phone ________________

MOTHER'S

First Name ________________________________ SS# ________________
Employed by ________________________________ Position ________________
Bus. Address ________________________________ Phone ________________

MEDICAL HISTORY

YES	NO	
❑	❑	Anemia
❑	❑	Blood Diseases
❑	❑	Hepatitis
❑	❑	Risk Group for AIDS
❑	❑	Jaundice
❑	❑	Rheumatic Fever
❑	❑	Heart Diseases
❑	❑	Tuberculosis
❑	❑	Diabetes
❑	❑	Endocrine Problems
❑	❑	Bone Disorders
❑	❑	Epilepsy

YES	NO	
❑	❑	Oral Herpes
❑	❑	Tonsillitis/Adenitis
❑	❑	Tonsils Removed
❑	❑	Adenoids Removed
❑	❑	Asthma
❑	❑	Allergies
❑	❑	Drug Sensitivity
❑	❑	Under Physicians Care?
❑	❑	Systemic Medication?
❑	❑	Unusual Illness?
❑	❑	In Good Health?

DENTAL HISTORY

YES	NO	
❑	❑	Speech Problems
❑	❑	Head/Face Injuries
❑	❑	Dental Injuries
❑	❑	Thumb/Finger Habit
❑	❑	Difficult Oral Surgery
❑	❑	Clench/Grind Teeth
❑	❑	Missing/Extra Permanent Teeth
❑	❑	Clicks/Pops of Jaw Joint

DATE OF LAST DENTAL CHECKUP ________________

Girls: Has menstruation begun ❑ Yes ❑ No When? ________________________________

Boys: Has voice changed ❑ Yes ❑ No When? ________________________________

In case of emergency call: ____

Parent/Guardain signature: ____

For Office Use
COMMENTS FROM HISTORY: ____

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