Adam Goodman, D.M.D.

Orthodontics for Adults & Children 440 East 57th Street, New York, NY 10022

Patient's Name:	☐ M ☐ F	Today's Date: / /
Address:	Date of Birth: / /	
City/State/Zip:	Referred by:	
Mother's Name:	Father's Name:	
Mother's Cell:	Father's Cell:	
Mother's Work Phone:	Father's Work Phone:	
Email :	Email:	
Financially Responsible Party:		
Address		
Patient's School:		
General Dentist:	Dentist Phone Number:	
Approximate date of last dentist visit:	For what service?	
Any incidents of trauma to the dentition? ☐Yes ☐No	Describe the injury:	
Is the patient a mouth breather, or snore at night?	☐ Yes ☐ No	
Did the patient ever suck their thumb or use a pacifier past age 3?	☐ Yes ☐ No	

CHILD'S GENERAL HEALTH HISTORY

Physician:	Physician Phone Number:
Does the patient require Antibiotic Prophylaxis for dental procedures, or do you have a heart murmur or prosthetic valve?	☐ Yes ☐ No Explain:
Are there emotional or behavioral problems?	☐ Yes ☐ No Explain:
Is the patient allergic to any medication?	☐ Yes ☐ No Explain:

Has the patient have any history of, or difficulty with any of the following:			If none of the below conditions apply, please check___	
☐ Anemia	☐ Chronic sinus	☐ Bleeding Disorders	☐ Hearing	☐ Malignancies
☐ Asthma	☐ Convulsions	☐ Fainting	☐ Intestinal	☐ Mononucleosis
☐ Canker Sores	☐ Diabetes	☐ Heart	☐ Kidney	☐ Skin
☐ HIV +	☐ Hepatitis	☐ Oral herpes	☐ Headaches	☐ Mitral Valve Prolapse

Any history or conditions not mentioned above, which might relate to orthodontic treatment:

Your relation to the patient:

Signature:	**Print Name:**