SAM H. ARAZIE, D.M.D., M.S.D., P.A.
Welcome to Our Office

-- Please Print --

DATE OF BIRTH _____ DATE _____ 20 _____

Patient's Name _____ Age _____ Sex: Male ❑ Female ❑
First Middle Last

Name Patient Prefers to be Called _____ Telephone Number _____

Home Address: Street _____ City _____ State _____ Zip Code _____

Email _____ School _____ Grade _____ Last Visit to Dentist _____

Patient's Hobbies or Interest _____

Patient's Dentist _____

IS THERE SOMEONE OTHER THAN YOUR DENTIST THAT WE MAY THANK FOR REFERRING YOU TO OUR OFFICE? (FRIENDS, NEIGHBORS, PATIENTS, ETC.) _____

Father's Name _____ DOB _____ Occupation _____

Employed by _____ Business Telephone _____

Business Address _____ Soc. Sec. No. _____

Mother's Name _____ DOB _____ Occupation _____

Employed by _____ Business Telephone _____

Business Address _____ Soc. Sec. No. _____

Name of Person Responsible for Account _____ Email _____

Relationship to Patient _____

Marital Status: Married ❑ Divorced ❑ Separated ❑ Single ❑Widowed ❑

Names and Ages of Other Children in Family _____

Do you have dental insurance that covers orthodontic treatment? Yes ❑ No ❑

Is the patient under the care of a physician for a specific problem at the present time? Yes❑ No❑ Illness_____

List any medicines your child is currently taking _____

List any drug sensitivities _____

Is there a history of serious illness, accident or operation? _____

If so, list. _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

❑ Contact Lenses	❑ High Blood Pressure	❑ Allergies or Asthma	❑ Speech Problems
❑ Glaucoma	❑ Head or Facial Injury	❑ Rheumatic Fever	❑ Emotional Problems
❑ Heart Trouble	❑ Tonsillitis	❑ Diabetes	❑ Endocrine Problems
❑ Kidney Disease	❑ Hearing Disorder	❑ Bleeding Problems	❑ Nervous Problems
❑ Hepatitis/Liver Disease	❑ Ear Infections	❑ Epilepsy	❑ Adopted

Has the patient reached puberty?

Girls: Has she started menstruation? Yes ❑ No ❑ If yes, Month/Year_____

Boys: Has his voice changed? Yes ❑ No ❑

DENTAL HISTORY

Have there been any injuries to the face, mouth, teeth? _____ ❑ Yes ❑ No

Has the patient ever sucked a thumb or fingers? _____ ❑ Yes ❑ No

Until what age? _____

Has an orthodontist been consulted previously? _____ ❑ Yes ❑ No

Has the patient had any previous orthodontic treatment _____ ❑ Yes ❑ No

If so, by whom? _____

Have you been informed of any missing or extra permanent teeth? _____ ❑ Yes ❑ No

Please list any family members previously treated here. _____

What part of your child's orthodontic problem concerns you most? _____

_____

Additional information which you feel would help make your child's association with us more enjoyable. _____

_____

Member
American Association of
Orthodontists

THANK YOU

_____
Signature of Parent or Guardian