MARK L.M. POWELL, D.D.S., M.S.D.

SPECIALIST IN ORTHODONTICS

2076 BALDWIN | JENISON, MICHIGAN 49428 | TELEPHONE (616) 457-5866

Patient's Name ______________________ Patient's Email ______________________

Date of Birth ______________ Age ________ Sex ☐ Male ☐ Female School ______________

Address ______________________ City ______________ State ___ Zip ________

Patient's Phone ______________________ Patient's Cell ______________________

Patient's Dentist ______________________ Address ______________________

Referred by ____

FATHER / GUARDIAN / SELF

Name ______________________

Address ______________________

Phone ______________ Cell ______________

Date of Birth ________ S.S.# ______________

Driver's Lic. # ______________________

Employer ______________ Ph. # ________

Ortho Insurance Co. ______________________

Insurance I.D. # ______________________

MOTHER / GUARDIAN

Name ______________________

Address ______________________

Phone ______________ Cell ______________

Date of Birth ________ S.S.# ______________

Driver's Lic. # ______________________

Employer ______________ Ph. # ________

Ortho Insurance Co. ______________________

Insurance I.D. # ______________________

MEDICAL HISTORY

	YES	NO
Is patient under physician's care now	☐	☐
Is there any excessive bleeding when cut	☐	☐
Has patient ever been hospitalized	☐	☐
Have tonsils or adenoids been removed	☐	☐
Is patient receiving any medication	☐	☐
Are there any emotional problems	☐	☐
Has patient ever had surgery	☐	☐
Was patient absent from school or work more than five days last year due to illness	☐	☐
Has patient ever had an unusual reaction to any drugs	☐	☐

If the answer to any of the above questions is YES, please explain: ______________________

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Has patient had any of the following: (check)

☐ Anemia	☐ Chicken Pox	☐ Tuberculosis	☐ Kidney	☐ Mumps
☐ Asthma	☐ Chronic Sinus	☐ Hepatitis	☐ Liver	☐ Rheumatic Fever
☐ HIV	☐ Convulsions	☐ Herpes	☐ Malignancies	☐ Speech
☐ Allergies	☐ Diabetes	☐ Hearing	☐ Measles	☐ Thyroid
☐ Cerebral Palsey	☐ Epilepsy	☐ Heart	☐ Mononucleosis	☐ Other ________

DENTAL HISTORY

	YES	NO
Trauma to the dental area? (chipped tooth, root canals, fractures)	☐	☐
Operations in the dental area?	☐	☐
Previous Orthodontic Examination?	☐	☐
Previous Orthodontic Treatment?	☐	☐
Does the patient play a musical instrument?	☐	☐
Thumb sucking or nail biting habits?	☐	☐
Are either of the above active at the present time?	☐	☐
Does the patient (if a minor) have any brothers or sisters?	☐	☐

State ages: ______________________

	YES	NO
Have any had Orthodontic Treatment?	☐	☐
Have any been treated by Dr. Powell?	☐	☐

Please make any comments that you feel may be helpful:

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____

Signature: ______________________________ Date: ______________

☐ Parent ☐ Guardian ☐ Patient