Kurt Kavanaugh Orthodontics – Personal Medical and Dental History

Kansas City Location – 8407 N. Main Street, Kansas City, MO 64155 – 816-420-8100 Sedalia Location – 4400 S. Limit, Sedalia, MO 65301 – 660-829-2900

Today's date: _____

Your careful and complete answers to the following questions will be helpful in the evaluation of your orthodontic condition. Please print.

Patient's Name		Nickname			
Mailing Address					
City, State, Zip					
Patient/Parent e-mail address					
Home Phone () Ce	II ()	Work ()			
Date of Birth	Present Age _	years	months		
Patient's Social Security Number					
School patient attends					
Patient's Place of Employment					
Employer's Address					
Name of individual completing this form	Relationship to patient				
Who to contact in case of an emergency		Phone			
Referred to our office by					
Patient's hobbies or interests					
General Dentist's Name	Date of last cleaning				
Address					
Physician's Name					
Address					
(Please fill o	ut the following if the patie	nt is a minor)			
Father's name	Father's Social Secu	rity Number			
Father's mailing address					
Father's Home Phone ()	Cell ()	Work ()			
Occupation	Father's Date of Bir	th			
Mother's name	Mother's Social Sec	urity Number			
Mother's mailing address					
Mother's Home Phone ()					
Occupation					
•					
Name of person(s) responsible for this according	unt	Relationship to patient _			

List illnesses other than usual childhood disease At what age they occurred List injuries or operations of the head and neck At what age did they occur? List all allergies (including drug allergies) So that we may take future growth potential into account, please indicate if the patient has not started puberty, is going through puberty right now, is past puberty Please check and comment on the following that are applicable to the patient: Tubes in ears Sinus trouble Mouth breathing (awake/asleep) Rheumatic Fever Heart, Blood Special Diets Convulsions Asthma Sleeplessness Rheumatic Fever Heart, Blood Special Diets Convulsions Asthma Sleeplessness High Blood Pressure Contact Lenses Kidney Problems Gagging, Nausea Tuberculosis Diabetes [Women) Are you pregnant? Noticeable change in weight or height in the past year Yes No	How is the patient's general health now?				
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Mail, Fax or Email all forms to:

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