

**Greg W. Sutherland, D.D.S., M.S. & P.S.**  
Orthodontic Specialist  
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A B C

### Patient Information

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Patient's Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last First Middle

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

School \_\_\_\_\_ Grade \_\_\_\_\_ Social Security # \_\_\_\_\_

If Patient is a minor, give parents' or guardians' names \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Physician \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Special Interests: \_\_\_\_\_

### Responsible Party Information

**Name** \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Residence (if different from patient's) \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_

Previous Address ( if less than 3 yr.) \_\_\_\_\_  
Street City State Zip

**Spouse's Name** \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Middle

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Emergency Information

Name of nearest relative not living with you \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Phone \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained. I give permission to Dr. Sutherland's office to perform an examination.

**Signature** (Parent's signature if minor) \_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES**

## Medical History

Is the patient currently under the care of a physician? .....  Yes  No

Please explain: \_\_\_\_\_

Does the patient suffer with frequent colds or sore throats? .....  Yes  No

Have the patient's tonsils and/or adenoids been removed? .....  Yes  No

Does the patient have any allergies or drug sensitivities? .....  Yes  No

Please list: \_\_\_\_\_

Has the patient ever had any of the following diseases or medical problems?

Diabetes.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Problems .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pneumonia .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Involvement .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bone Disorders .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prolonged Bleeding .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting/Dizziness .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Disorders .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Problems .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Has the patient ever tested positive for Acquired Immune Deficiency Syndrome? .....  Yes  No

Is the patient currently taking any prescription or over-the-counter drugs? .....  Yes  No

Please list each medication and the reason it is being taken: \_\_\_\_\_

## Dental History

Do you have any friends or relatives who are past or present patients of Dr. Sutherland's? \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Approximate date of last check up \_\_\_\_\_

Yes  No Did your dentist refer you to our office?  
Does your dentist have specific concerns? \_\_\_\_\_

Yes  No Is there any dental work that needs to be completed?

Yes  No Have there been any injuries to the face, mouth or teeth?  
Please explain \_\_\_\_\_

Yes  No Has the patient ever sucked a thumb or finger?

Yes  No Does the patient have any speech problems?

Yes  No Is the patient a mouth breather?

Yes  No While awake?

Yes  No While asleep?

Yes  No Has the patient been informed of any missing permanent teeth?

Yes  No Has the patient been informed of any extra permanent?

Yes  No Has the patient had any permanent teeth extracted?

Yes  No Does the patient grind or clench his/her teeth?

Yes  No Does the patient experience popping/clicking in the jaw joints?

Yes  No Has the patient's jaw ever locked on him/her?

Yes  No Has the patient ever consulted an orthodontist previously?  
If so, when and where? \_\_\_\_\_

Yes  No Was orthodontic treatment recommended?

Yes  No Have any other members of the family had orthodontic treatment? Who? \_\_\_\_\_

If you could change anything about you/your child's smile or bite, what would it be? \_\_\_\_\_