
Ronald F. Delia
Mark P. Zammit
Orthodontists

PATIENT HEALTH INFORMATION FORM - PLEASE COMPLETE FULLY –

Have you ever had any of the following? **(Please circle)**

Rheumatic Fever	yes no	Diabetes	yes no
Heart Disease	yes no	Hay Fever	yes no
Asthma	yes no	Kidney Disease	yes no
Liver Disease	yes no	Bleeding Disorders	yes no
Hepatitis	yes no	Tonsils and/or adenoids removed	yes no
Positive H.I.V.	yes no	Head / Facial injuries	yes no

Do you have any drug allergies? (If yes, indicate them bellow) yes no

Do you have any other allergies? (If yes, indicate them below) yes no

Is antibiotic premedication required prior to dental treatment? Yes no
Is there any discomfort when chewing, opening, or closing mouth? Yes no
Are you aware of any TMJ problems (click, pain, locking, etc.)? Yes no
Do you visit your family dentist on a regular basis? Yes no
Has another family member had braces or other orthodontic treatment? Yes no
Name of family member (If treated in out office) _____
Whom may we thank for referring you to our office? _____
Reason for visit our office? _____

Signature Date