

# HEALTH HISTORY

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Patient's Birthdate \_\_\_\_\_

Family Dentist \_\_\_\_\_

School (if student) \_\_\_\_\_

Family Physician \_\_\_\_\_

Grade \_\_\_\_\_

Race \_\_\_\_\_

## PLEASE CHECK ALL THAT APPLY

### DENTAL HISTORY

#### YES

- Has patient ever sucked thumb or finger?
- Does patient suck thumb or finger now?
- Does patient have any speech problems?
- Does patient have any difficulty in chewing food?
- Does patient clinch or grind teeth?
- Does patient have any pain in the jaws?
- Does patient have any clicking or popping when opening mouth?
- Does patient have bleeding gums?
- Has patient had any head or facial injuries?
- Has patient had any previous orthodontic treatment? (braces, retainers, etc.)
- Is patient embarrassed about the appearance of his or her teeth?
- Have any other family members had orthodontic treatment?

### MEDICAL HISTORY

Has patient ever had any of the following?

#### YES

- Bone fractures
- Reaction to any medication (Please list \_\_\_\_\_ )
- Allergies (Please list \_\_\_\_\_ )
- Sinus problems
- Tonsils or adenoids removed
- Bleeding problems
- Frequent sore throats
- Heart disease
- Rheumatic fever
- Hepatitis
- Aids or HIV positive
- Dizziness or fainting
- Frequent headaches
- Arthritis
- Diabetes
- Is patient's general health good?
- Is patient presently under a physician's care?
- Has patient ever been hospitalized? For what? \_\_\_\_\_
- Is patient taking any medications? Please list \_\_\_\_\_
- Does patient use tobacco products?  
Type? \_\_\_\_\_ How much? \_\_\_\_\_

Please list anything else you feel would affect orthodontic treatment.

\_\_\_\_\_

- Is patient in any sports? Please list \_\_\_\_\_

**Patient Information**

Date \_\_\_\_\_

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

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

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

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

**Responsible Party Information**

Responsible Party Name \_\_\_\_\_  
Last First Middle Marital Status

Residence \_\_\_\_\_  
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 years.) \_\_\_\_\_  
Street City State Zip

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

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

Spouse's Name \_\_\_\_\_  
Last First Middle Relationship to Patient \_\_\_\_\_

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

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

**Dental Insurance Information**

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Do you have dual coverage? Yes  No  If Yes:

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

**Authorization—Assignment of Benefits** (Signature of Insured) \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_

I Understand that where appropriate, credit bureau reports may be obtained.

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

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\_\_\_\_\_ (over)

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