HEALTH HISTORY

Patient Name _____ Date _____

Patient's Birthdate _____ Family Dentist _____

School (if student) _____ Family Physician _____

Grade _____ Race _____

DENTAL HISTORY

PLEASE CHECK ALL THAT APPLY

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?
- ☐ Has patient had dental cleaning and exam in last 6 months?

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 medication? (Please list _____)
- ☐ Does patient use tobacco products?

  Type? _____ How much? _____
- ☐ Have you traveled outside of the country in the last 21 days? _____

Please list anything else you feel would affect orthodontic treatment.

_____

_____

- ☐ Is patient in any contact sports? (Please list _____)
- ☐ Would patient benefit from mouthguard?

A B C

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthday _____ 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 _____

Email Address _____ Mobile Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

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) _____

OFFICE USE ONLY

Updated (date & initial) _____ _____ _____ _____

(over)