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 _____

A B C

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 _____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)