NEW PATIENT HEALTH HISTORY

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Patient's name _____
First Middle Initial Last Preferred Name (Nickname)

Address_____
Street APT# City State Zip

Birthdate_____ Gender _____ Primary Phone #_____ (may we leave a message: yes no)

Whom may we thank for referring you to our office? _____

FOR A CHILD PATIENT (PLEASE COMPLETE AS MUCH AS POSSIBLE):

School_____ **Grade** _____ **Sports/Hobbies/Interests** _____

_____

☐ **Father** ☐ **Step-Father** ☐ **Other**_____
First Middle Initial Last

Address_____
(If different from Patients) Street APT# City State Zip

Home phone_____ **Work phone** _____

Cell/other phone_____ **Email address**_____

Employer_____**Occupation**_____

☐ **Mother** ☐ **Step-Mother** ☐ **Other**_____
First Middle Initial Last

Address_____
(If different from Fathers/Patients) Street APT# City State Zip

Home phone_____ **Work phone** _____

Cell/other phone_____ **Email address** _____

Employer_____**Occupation**_____

Patient lives with: ☐ **BOTH FATHER & MOTHER** ☐ **FATHER** ☐ **MOTHER** ☐ **OTHER (Please Specify)**:_____

If divorced, who is the custodial parent? _____

FOR AN ADULT PATIENT (PLEASE COMPLETE AS MUCH AS POSSIBLE):

Your Employer/Occupation_____ **Work Phone** _____

Cell Phone _____ **Email address** _____

Spouse's Name _____ **Employer** _____ **Occupation** _____

Cell Phone _____ **Email address** _____

May we leave a message at the phone numbers listed: YES or NO

May we email you regarding appointments and other correspondence? YES or NO

DENTAL INSURANCE INFORMATION

Do you have insurance that covers orthodontics? YES NO

If yes please fill in the following information:

Insurance Co._____State: _____
Employer: _____
Policy Holder:_____
Birth Date: _____
Social Sec. / ID# **(required)** _____
Ins. Co. Phone _____Group# _____

If there is a second insured party, please fill in below:

Insurance Co._____State: _____
Employer: _____
Policy Holder:_____
Birth Date: _____
Social Sec. / ID# **(required)** _____
Ins. Co. Phone _____Group# _____

(OVER)

DENTAL HISTORY

General Dentist_____ Date of last visit_____
Address_____Phone_____

Are you currently seeing another Dental Specialists? YES NO If yes, who? _____ Reason:_____

What are the patient's concerns about his/her teeth?_____

Yes No Is the patient presently in any dental pain?_____
Yes No Have there been any injuries to face, mouth, or teeth? _____
If yes, please explain: _____
Yes No Is there any sensitivity to temperature? Where? _____
Yes No Is there any sensitivity to pressure? Where? _____
Yes No Does the patient have any missing or extra permanent teeth? _____
Yes No Does the patient have any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather?_____
Yes No Any TMJ (jaw joint) symptoms? **IF YES, Please Mark those that apply:**

☐ GRINDING ☐ CLENCHING ☐ JAW JOINT NOISES ☐ HEADACHES or NECKACHES ☐ JAW JOINT PAIN
☐ FACIAL or EAR PAIN ☐ LOCKING or DIFFICULTY MOVING JAWS ☐ DENTAL or FACIAL TRAUMA ☐ ARTHRITIS

Comments: _____

TO BE COMPLETED FOR CHILD PATIENTS ONLY:

Brother/Sister Name:_____ Birth date: _____ Had ortho treatment? ☐ Yes ☐ No
If yes, where: _____

Brother/Sister Name:_____ Birth date: _____ Had ortho treatment? ☐ Yes ☐ No
If yes, where: _____

Brother/Sister Name:_____ Birth date: _____ Had ortho treatment? ☐ Yes ☐ No
If yes, where: _____

Brother/Sister Name:_____ Birth date: _____ Had ortho treatment? ☐ Yes ☐ No
If yes, where: _____

Brother/Sister Name:_____ Birth date: _____ Had ortho treatment? ☐ Yes ☐ No
If yes, where: _____

ORTHODONTIC HISTORY

Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No Has anyone in the family received orthodontic treatment in this office? _____
Yes No Are you aware that some appointments will be during school/work hours?_____
What is the patient's attitude toward receiving orthodontic treatment?_____

MEDICAL HISTORY

Physician _____ Phone _____

Address _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient allergic to: ☐ METALS ☐ LATEX ☐ ACRYLICS ☐ LOCAL ANESTHETICS
Yes No Has the patient been advised that antibiotics should be taken prior to dental procedures? _____
Yes No Is the patient taking any medication(s)? If Yes, please list: _____
_____
Yes No Is the patient allergic to any medication(s)? If Yes please list: _____
Yes No History of a major illness? _____
Yes No Height of parents: Mom_____ Dad_____

Female Patients only:
Yes No Is the patient pregnant? _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. ***For the following questions, please mark, yes, no or don't know/understand (dk/u).***

NOW OR IN THE PAST, HAS THE PATIENT HAD:

☐ yes ☐ no ☐ dk/u Does the patient have learning disabilities or need extra help with instructions?

☐ yes ☐ no ☐ dk/u Mental health or emotional problems?

☐ yes ☐ no ☐ dk/u Birth defects or hereditary problems?

☐ yes ☐ no ☐ dk/u Bone fractures, or major injuries?

☐ yes ☐ no ☐ dk/u Any injuries to face, head, neck?

☐ yes ☐ no ☐ dk/u Arthritis or joint problems?

☐ yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?

☐ yes ☐ no ☐ dk/u Endocrine or thyroid problem?

☐ yes ☐ no ☐ dk/u Diabetes or low blood sugar?

☐ yes ☐ no ☐ dk/u Kidney problems?

☐ yes ☐ no ☐ dk/u Immune system problems?

☐ yes ☐ no ☐ dk/u History of osteoporosis?

☐ yes ☐ no ☐ dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?

☐ yes ☐ no ☐ dk/u AIDS or HIV positive?

☐ yes ☐ no ☐ dk/u Hepatitis, jaundice or other liver problems?

☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?

☐ yes ☐ no ☐ dk/u Seizures, fainting spells, neurologic problem?

☐ yes ☐ no ☐ dk/u Mental health disturbance or depression?

☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?

☐ yes ☐ no ☐ dk/u History of stomach ulcer and/or acid reflux?

☐ yes ☐ no ☐ dk/u Frequent headaches or migraines?

☐ yes ☐ no ☐ dk/u High or low blood pressure?

☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising tendency, anemia?

☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath, tire easily, swollen ankles?

☐ yes ☐ no ☐ dk/u Heart defects, heart murmur, rheumatic heart disease?

☐ yes ☐ no ☐ dk/u Angina, arteriosclerosis, stroke or heart attack?

☐ yes ☐ no ☐ dk/u Skin disorder (other than common acne)?

☐ yes ☐ no ☐ dk/u Vision, hearing, or speech problems?

☐ yes ☐ no ☐ dk/u Frequent ear infections, colds, throat infections?

☐ yes ☐ no ☐ dk/u Asthma, sinus problems, hayfever?

☐ yes ☐ no ☐ dk/u Tonsil or adenoid condition?

☐ yes ☐ no ☐ dk/u Does the patient frequently breath through his/her mouth?

☐ yes ☐ no ☐ dk/u Has the patient ever taken intravenous bisphosphonates such as Zometa (zolendromic acid) Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?

☐ yes ☐ no ☐ dk/u Has the patient ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

I certify that the preceding information is true and correct. **If there are any future changes in this information, I will inform the practice of these changes.** I realize that any diagnostic records taken in this office are the property of this office. We will be happy to furnish, upon request, a copy of these records to another orthodontist for a fee.

Signature: _____ Date: _____