Patient Health History

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PATIENT INFORMATION

First Name	Middle Initial	Last Name	Responsible Party	Cell Phone	Home Phone
Nickname	Birth Date	M/F	Email		
Address	City		Responsible Party	Cell Phone	Home Phone
State	Zip		Email		
Cell Phone	Home Phone		Names of any friends or family currently in the practice		
Sports, hobbies, or musical instruments played			Whom may we thank for referring you to our practice?		

FINANCIAL/INSURANCE INFORMATION

First Name	Middle Initial	Last Name	Employer	Work Phone
Address		City	Name of Dental Insurance	
State		Zip	Subscriber's Name	Subscriber's DOB
Cell Phone	Home Phone	Email	Subscriber's ID/ Social Security No.	Relationship to Patient

DENTAL HISTORY

Dentist Name			Speech problems/therapy?	Yes	No	Floss teeth daily?	Yes No
			Grind or clench teeth?	Yes	No	Fluoride treatments?	Yes No
Check-up Frequency		Last Dental Visit	Oral habits (thumb/finger habit, lip/nail biting)?	Yes	No	Mouth breathing?	Yes No
			Injury to face, jaw, teeth, or mouth?	Yes	No	Snores during sleep?	Yes No
Has patient had an orthodontic consult or treatment? If so, when?			Discomfort from teeth or gums?	Yes	No	Requires premedication?	Yes No
			Pain, tenderness, or noise in either jaw?	Yes	No	Any missing or extra permanent teeth?	Yes No
What is the patient's main orthodontic concern?			Frequent headaches?	Yes	No	Apprehensive about dental care?	Yes No
			Neck/shoulder pain?	Yes	No	Frequent sore throats?	Yes No
			Brush teeth daily?	Yes	No	Frequently chews gum?	Yes No

MEDICAL HISTORY

Physician Name and Address			List medications currently being taken by the patient			List drug allergies or sensitivities patient may have		
			Date of Last Physical			Patient Health		
Rheumatic Fever	Yes	No	HIV/AIDS	Yes	No	Seizures/Epilepsy	Yes	No
Tuberculosis/Lung Disease	Yes	No	Hepatitis	Yes	No	Handicaps/Disabilities	Yes	No
Pneumonia	Yes	No	Tonsils/Adenoids Removed	Yes	No	Asthma	Yes	No
Liver Disease	Yes	No	Cancer	Yes	No	Arthritis	Yes	No
Kidney Disease	Yes	No	Family History of Cancer	Yes	No	ADHD/ADD/Autism	Yes	No
Heart Attack/Stroke	Yes	No	Received Radiation Treatment	Yes	No	Treated for Emotional Problems	Yes	No
Heart Disease	Yes	No	Growth Problems	Yes	No	Ever Been Hospitalized	Yes	No
Congenital Heart Defect	Yes	No	Endocrine Problems	Yes	No	If any of the above were answered "yes," please explain:		
Heart Murmur	Yes	No	Hormone Therapy	Yes	No			
Hemophilia	Yes	No	Latex/Metal Allergy	Yes	No			
Hypertension/High Blood Pressure	Yes	No	Nervous Disorders	Yes	No			
Prolonged Bleeding/Transfusion	Yes	No	Bone Disorders/Bone Loss	Yes	No	List any other illness not listed:		
Anemia	Yes	No	Diabetes	Yes	No			

The information I have provided is true and complete.

Parent/Guardian/Independent Patient _____ Date _____

Orthodontist's Signature _____