CONFIDENTIAL

WELCOME!

To help us meet your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION

Name_____ Date_____
Social Security Number_____ Home Phone_____
Date of Birth_____ Age_____ Sex M/F Cell Phone_____
Email Address_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
If Student, Name of School_____
If Minor, Name of Parent(s)/Guardian(s)_____
Person to Contact in Case of Emergency_____ Phone_____
How Did You Find Out About Us?_____

RESPONSIBLE PARTY INSURANCE INFORMATION

Name of Insured/Person Responsible for this Account_____ Relationship to Patient_____
Address_____ City_____ State_____ Zip_____
Email Address_____ Home Phone_____
Driver's License Number_____ Social Security Number_____
Date of Birth_____ Employer_____ Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____ Policy/ID#_____
Ins. Co. Address_____ City_____ State_____ Zip_____

PHYSICIAN / DENTIST INFORMATION

Physician_____ Office Phone_____ Date of Last Exam_____
Dentist_____ Office Phone_____ Date of Last Exam/ Cleaning_____
Does patient need to return to dentist for any fillings or other procedures? Yes / No
If yes, please describe: _____

What is the patient's (parent's) primary concern – why are you here?

_____

_____

Over Please

PATIENT MEDICAL HISTORY

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgery or serious illness in the past 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, which medications? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐

8. Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐
9. Women only:		
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

10.Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Tonsil/Adenoid Problems	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement, Implant	☐	☐	Eye, Ear, Throat Problems	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Trouble/Ulcers	☐	☐	Other_____	☐	☐

PATIENT DENTAL HISTORY

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Do you feel pain from any of your teeth?	☐	☐
4. Do you have any lumps or sores in your mouth?	☐	☐
5. Have you had any head, neck or jaw injuries?	☐	☐
6. Have you ever experienced any of the following problems in your jaw joints:		
Clicking	☐	☐
Pain	☐	☐
Difficulty opening or closing	☐	☐

	Yes	No
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you bite your lips or cheeks frequently?	☐	☐
10.Have you ever had difficult extractions?	☐	☐
11.Have you had any thumb or finger sucking habit? Until _____	☐	☐
12.Do you have an abnormal swallow, tongue thrust, or speech problem?	☐	☐
13.Do you usually breath through your mouth?	☐	☐
14.Have you had any orthodontic treatment? If yes, what? _____	☐	☐

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

_____ _____

Signature of Parent/Patient Date

Medical History Update or Changes: _____