Health History

Patient Information Child

Patient's Name_____ DOB _____ Age_____

Nick Name_____ Male Female

School_____

Home Address_____

City _____ State_____ Zip _____

Phone_____ Cell Phone_____

Who may we thank for referring you?_____

Main Concern For Orthodontic Treatment_____

Parent's Information

Mother's Name_____

Phone_____ Cell Phone_____

Home Address (if different from patient)_____

City_____ State_____ Zip_____

Father's Name_____

Phone_____ Cell Phone_____

Home Address (if different from patient)_____

City_____ State_____ Zip_____

Financial Responsible Party Information

Responsible Party Name_____

Phone_____ Cell Phone_____

Work Phone_____

Email_____

Home Address (if different from patient)_____

City_____ State_____ Zip_____

SSN_____ DL#_____

Insurance Information

Primary Insurance Company & Address_____

Phone Number_____

Employer_____ Group Number_____

Subscriber Name_____ Subscriber ID_____ Birthdate_____

Secondary Insurance Company & Address_____

Phone Number_____

Employer_____ Group Number_____

Subscriber Name_____ Subscriber ID_____

Dental History

Dentist's Name_____ Office Location_____

Now or in the past has the patient:

Yes No Started teething very late or early?

Yes No Primary (baby) teeth removed that were not loose?

Yes No Permanent or "extra" teeth removed?

Yes No Teeth sensitive to hot or cold; teeth throb or ache?

Yes No Jaw fractures, cysts or mouth infections?

Yes No "Dead teeth" or root canals treated?

Yes No Bleedings gums, bad taste or mouth odor?

Yes No Periodontal disease "Gum Problems"

Yes No Food impaction between teeth?

Yes No Abnormal swallowing habit (tongue thrusting)?

Yes No History of speech problems?

Yes No Mouth breathing habit, snoring, difficulty breathing?

Yes No Tooth grinding or jaw clinching?

Yes No Any pain in jaw or ringing in ears?

Yes No Any pain or soreness in the muscles of the face or around the ears?

Yes No Difficulty when chewing or jaw opening?

Yes No Aware of loose, broken or missing fillings?

Yes No Any teeth irritating cheek lip, tongue or palate?
Yes No Concerned about spaced, crooked or protruding teeth?
Yes No Aware of under or over developed lower jaw?
Yes No Frequent canker sores or cold sores?
Yes No Taking any forms of fluoride?
Yes No Any relative with similar tooth or jaw relationship?
Yes No Had periodontal (gum) treatment?
Yes No Would you object to wearing orthodontic appliances (braces) if they are recommended?
Yes No Any serious trouble associated with any previous dental treatment?
Yes No Ever had a prior orthodontic examination or treatment?

Office Use Only

TX MO:_____
APPL:_____
CLN DN: YES NO
REFER:_____
Sp's **Upr/ Lwr**

Now or in the past has the patient had:

Yes No Birth defects or hereditary problems?
Yes No Bone fractures, or major accidents?
Yes No Endocrine or thyroid problems?
Yes No Kidney problems?
Yes No Diabetes?
Yes No Cancer, tumor, radiation treatment or chemotherapy?
Yes No Stomach ulcer or hyperactivity?
Yes No Polio, mononucleosis, tuberculosis, pneumonia?
Yes No Problems of the immune system?
Yes No AIDS or HIV positive?
Yes No Hepatitis, jaundice or liver problems?
Yes No Fainting spells, seizures, epilepsy or neurological problem?
Yes No Mental health disturbance or depression?
Yes No Vision, hearing, tasting or speech difficulties?
Yes No Loss of weight recently, poor appetite?
Yes No History of eating disorder (anorexia, bulimia)?
Yes No Excessive bleeding anemia or bleeding disorder?
Yes No High or low blood pressure?
Yes No Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
Yes No Skin disorder?
Yes No Tired easily?
Yes No Chest pain, shortness of breath or swelling ankles?
Yes No Does the patient eat a well balanced diet?
Yes No Frequent head aches, colds or sore throats?
Yes No Ear, nose & throat condition?
Yes No Hay fevers, asthma, sinus trouble or hives?
Yes No Tonsil or adenoid condition?

Allergies or reactions to any of the following:

Yes No Local anesthesia (Novocain, Lidocain)?
Yes No Aspirin
Yes No Sulfa Drugs
Yes No Vinyl
Yes No Acrylic
Yes No Latex
Yes No Animals
Yes No Penicillin or other antibiotics _____
Yes No Codeine or other narcotics _____
Yes No Metals (jewelry, clothing snaps)
Yes No Ibuprofen (Motrin, Advil)
Yes No Foods (specify) _____
Yes No Other substances (specify) _____

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

Signed: (parent, Guardian or Self if over 18_____ Date:_____
Doctor's Signature:_____ Date:_____