

New Patient Health History

Patient Biological Information

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|---------------------------------------------------------------------------|------------------------------|-----------------|------|
| First Name: | Middle Initial: | Last Name: | |
| Date of Birth: | Gender: Male/Female | Nickname: | |
| Address: | City: | State: | Zip: |
| Home Phone: | 2 nd /Cell Phone: | E-Mail Address: | |
| Please list the names of any friends or family currently in the practice: | | | |
| Whom may we thank for referring you to our practice? | | | |

Financial Party Information

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|-------------------------------------------------|------------------------------|--------------------------|------|
| First Name: | Middle Initial: | Last Name: | |
| Address: | City: | State: | Zip: |
| Home Phone: | 2 nd /Cell Phone: | E-Mail Address: | |
| Social Security #: | Employer: | Occupation: | |
| Length of Employment: | Work Phone: | Relationship to Patient: | |
| Do you have insurance that covers orthodontics? | YES | NO | |
| If so, Please name the Insurance Company: | | | |

Dental History

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|--------------------------------------------------------------------------|-------------------|----|-------------------------------------------|-----|----|
| Dentist Name: | Last Dental exam: | | | | |
| Has Patient had an orthodontic consult or treatment? | YES | NO | | | |
| If so, when? | | | | | |
| What is patient's main orthodontic concern? | | | | | |
| Brush teeth daily? | YES | NO | Snores during sleep? | YES | NO |
| Floss teeth daily? | YES | NO | Sleep issues (daytime fatigue, apnea) | YES | NO |
| Fluoride treatment? | YES | NO | Injury to face, jaw, teeth, or mouth? | YES | NO |
| Discomfort from teeth or gums? | YES | NO | TMJ/TMD issues? | YES | NO |
| Apprehensive about dental care? | YES | NO | Pain, tenderness, or noise in either jaw? | YES | NO |
| Any missing or extra permanent teeth? | YES | NO | Grind or clench teeth? | YES | NO |
| Oral Habits (thumb/finger habit, lip/nail biting) | YES | NO | Neck/shoulder pain? | YES | NO |
| Mouth breather? | YES | NO | Frequent headaches? | YES | NO |
| Speech problems? | YES | NO | Frequently chews gum? | YES | NO |
| If any of the above dental questions were answered "Yes" please explain: | | | | | |

Medical History

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|-----------------|------------------------|-----------------|
| Physician Name: | Date of last Physical: | Patient Health: |
| Address: | City: | State: Zip: |

List any medications currently being taken by the patient:

List any drug allergies or sensitivities that patient may have:

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|----------------------------------|-----|-----|----------------------------------|------------------------------|-----|----|
| Rheumatic Fever | YES | NO | Cancer | YES | NO | |
| Tuberculosis/Lung Disease | YES | NO | Family History of Cancer | YES | NO | |
| Pneumonia | | YES | NO | Received Radiation Treatment | YES | NO |
| Liver Disease | YES | NO | Growth Problems | YES | NO | |
| Kidney Disease | YES | NO | Endocrine Problems | YES | NO | |
| Heart Attack/Stroke | YES | NO | Hormone Therapy | YES | NO | |
| Heart Disease | YES | NO | Latex/Metal Allergy | YES | NO | |
| Congenital Heart Defect | YES | NO | Nervous Disorder | YES | NO | |
| Heart Murmur | YES | NO | Bone Disorders/Bone Loss | YES | NO | |
| Hemophilia | YES | NO | Taken Bisphosphonate Medications | YES | NO | |
| Hypertension/High Blood Pressure | YES | NO | Diabetes | YES | NO | |
| Prolonged Bleeding/Transfusion | YES | NO | Seizures/Epilepsy | YES | NO | |
| Anemia | YES | NO | Handicaps/Disabilities | YES | NO | |
| HIV/AIDS | YES | NO | Asthma | YES | NO | |
| Hepatitis | YES | NO | Arthritis | YES | NO | |
| Tonsils/Adenoids Removed | YES | NO | Treated for Emotional problems | YES | NO | |
| Ever Been Hospitalized | YES | NO | | | | |

If any of the above medical questions were answered "Yes" Please explain:

Patients Under 18

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|-------------------------|---------|-------------------------|--------|
| Height: | Weight: | School: | Grade: |
| Father/Guardian 1 Name: | | Mother/Guardian 2 Name: | |

| | | |
|-----------------------------------------------------------------------------|-----|----|
| Has patient begun puberty? | YES | NO |
| If patient is a girl, has menstruation begun? | YES | NO |
| If so, have cycles been regular for 1 year? | YES | NO |
| If patient is a boy, has their voice changed and/or shaving | YES | NO |
| Has patient grown in the past year or has their shoe size changed recently? | YES | NO |
| Is patient interested in orthodontic treatment? Positive attitude? | YES | NO |
| Has either biological parent ever had orthodontic treatment? | YES | NO |

Please list the name and birthdate of any siblings:

Signature _____

Date _____