



**PATIENT INFORMATION**

Patient Name \_\_\_\_\_

Preferred Name \_\_\_\_\_  
\_\_\_\_\_

Gender \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_

State, Zip \_\_\_\_\_

Patient Home Phone \_\_\_\_\_

Patient Work Phone \_\_\_\_\_

Patient Cell Phone \_\_\_\_\_

Patient E-mail \_\_\_\_\_

School / Occupation \_\_\_\_\_

Sports / Hobbies \_\_\_\_\_

Family Dentist \_\_\_\_\_

Dentist Phone \_\_\_\_\_  
\_\_\_\_\_

Physician \_\_\_\_\_

Physician Phone \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Have we seen other family members? \_\_\_\_\_  
Who? \_\_\_\_\_

Names/ages of siblings or children \_\_\_\_\_

Have you seen another Orthodontist? \_\_\_\_\_  
Who? \_\_\_\_\_

The reason you seek orthodontic treatment \_\_\_\_\_

**If patient is a child:**

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Parents Marital Status is: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Child Lives with: \_\_\_\_\_

**RESPONSIBLE PARTIES**

Names of financially responsible parties/legal guardians

**Primary**

Name \_\_\_\_\_

Relation to patient \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_

State & Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_  
\_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_  
\_\_\_\_\_

Dental Insurance \_\_\_\_\_

Insurance ID# \_\_\_\_\_

Insurance Phone \_\_\_\_\_

**Secondary**

Name \_\_\_\_\_

Relation to patient \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_

State & Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_  
\_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_  
\_\_\_\_\_

Dental Insurance \_\_\_\_\_

Insurance ID# \_\_\_\_\_

Insurance Phone \_\_\_\_\_

**MEDICAL HISTORY**

General Health	Excellent	Good	Fair	Poor	Height	Weight
					_____	_____
Birth Defects	_____					
Allergic to what medications?	_____					
Presently under medical care for	_____					
Drugs or medications being taken now (drug & dosage)	_____					
Other medical information we should be aware of:	_____					

\* Is premedication required for dental visits? \_\_\_\_\_ If yes, which antibiotic do you take? \_\_\_\_\_

**Please answer Yes or No to the following and indicate the date:**

Adopted Child	Yes	No	Date _____	Emotional	Yes	No	Date _____	Learning Disorder	Yes	No	Date _____
Adenoids (removed)	Yes	No	_____	Endocrine Disorder	Yes	No	_____	Liver Disorder	Yes	No	_____
AIDS	Yes	No	_____	Epilepsy	Yes	No	_____	Rheumatic Fever	Yes	No	_____
Allergies	Yes	No	_____	Eye Disorders	Yes	No	_____	Scoliosis	Yes	No	_____
Blood/Bleeding Problems	Yes	No	_____	Fainting Spells	Yes	No	_____	Seizures/Convulsions	Yes	No	_____
Breathing Difficulties	Yes	No	_____	Heart Disorder/Murmur	Yes	No	_____	Speech Difficulty	Yes	No	_____
Bone Disorder	Yes	No	_____	Hearing Difficulties	Yes	No	_____	Tonsils(removed)	Yes	No	_____
Cerebral Palsy	Yes	No	_____	Hepatitis	Yes	No	_____	Tuberculosis	Yes	No	_____
Diabetes	Yes	No	_____	Hospitalized	Yes	No	_____	STD	Yes	No	_____
Ear/Nose Infections	Yes	No	_____	Hyperactivity	Yes	No	_____	Other			_____

**DENTAL HISTORY**

Date of last dental checkup \_\_\_\_\_ Injury to the face or teeth? \_\_\_\_\_

Jaw joint (TMJ problems) Noise Pain Earaches/Headaches Soreness/Stiffness

Other dental information we should be aware of \_\_\_\_\_

Other Habits (thumb, nail biting, etc.) \_\_\_\_\_

Breathing Nose Mouth Difficulty at night Snoring

Mouth Usually open Frequently open Seldom open

**Please answer Yes or No to the following due to a poor bite and indicate the date:**

Worn or sore teeth	Yes	No	Date _____	Headaches	Yes	No	Date _____	Limited opening	Yes	No	Date _____
Loose teeth	Yes	No	_____	Jaw/joint problems	Yes	No	_____	Difficulty chewing	Yes	No	_____
Bone/gum recession	Yes	No	_____	Bruxism/clenching	Yes	No	_____	Speech difficulty	Yes	No	_____

The information contained in this health history is true and correct to the best of my knowledge and I will advised the office of any changes in health status of the patient prior to any orthodontic visits.

\_\_\_\_\_  
Signature of person who filled out health history

\_\_\_\_\_  
Date