PATIENT INFORMATION

Patient Name _____

Preferred Name _____

Gender _____

Date of Birth _____ Age: _____

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 _____

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: _____

Names of financially responsible parties or 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 Heatlh Excellent Good Fair Poor Height _____ Weight _____

Birth Defects _____

Do you have a **Latex** allergy? _____

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:

			Date				Date				Date
Adopted Child	Yes	No	_____	Emotional	Yes	No	_____	Learning Disorder	Yes	No	_____
(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:

			Date				Date				Date
Worn or sore teeth	Yes	No	_____	Headaches	Yes	No	_____	Limited opening	Yes	No	_____
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***