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.

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Signature of person who filled out health history ***Date***