Patient Health History Form

Patient Name:

Confidential Patient Information			
First Name:	Middle Initial:	Last Name:	
Nickname:	Birthdate:	Gender:	
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Email:	
Please list the names of any friends or family currently in the practice:			
List any sports, hobbies, or musical instruments played:			
Whom may we thank for referring you to our practice:			

Patients Under 18	
Please list the name and birthdate of any siblings:	
School:	Grade:
Father/Guardian 1 Name:	Mother/Guardian 2 Name:
Patient's interest in treatment:	Biological parent ever had orthodontic treatment:

Financial Party Information			
First Name:	Middle Initial:	Last Name:	
Birthdate:	Relationship to Patient:	Email:	
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Social Security Number:	
Do you have insurance that covers orthodontics?	If so, please name the Insurance Company:		
Employer:	Occupation:	Length of Employment:	
Work Phone #:			

Medical History			
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 the patient may have:			
Please select YES or No for the Following Questions - Do Not Leave Blank			
ADHD	Autism	Celiac	
Herpes	Down Syndrome	Gastrointestinal Disorder	
Tuberculosis/Lung Disease	Pneumonia	Liver Problems	
Kidney Problems	Heart Problems	Hemophilia	
Hypertension/High Blood Pressure	Anemia	HIV/AIDS	
Hepatitis	Tonsils/Adenoids Removed	Cancer	
Growth Problems	Endocrine Problems	Latex/Metal Allergy	
Nervous Disorders	Bone Disorders/ Bone Loss	Diabetes	
Seizures/Epilepsy	Asthma	Arthritis	
Ever Been Hospitalized	Take Bisphosphonates (Fosamax, Boniva)		

If any of the above medical questions were answered 'Yes' , please explain:

Dental History		
Dentist Name:	Check-up Frequency:	Last Dental Visit:
Has the patient had and orthodontics consult or treatment?	If so, when?	
What is the patient's main orthodontic concern?		
Please select YES or No for the Following Questions - Do Not Leave Blank		
Speech problems/ therapy?	Grind or clench teeth?	
Injury to face, jaw, teeth or mouth?	Discomfort from teeth or gums?	
Pain, tenderness or noise in either jaw?	Oral habits (thumb/finger sucking, lip/nail biting)?	
Frequent sore throats?	Brush teeth daily?	
Floss teeth daily?	Fluoride treatments?	
Mouth breathing?	Snores during sleep?	
Requires premedication?	Any missing or extra permanent teeth?	
Apprehensive about dental care?	Frequently Chew Gum?	
If any of the above dental questions were answered 'Yes', please explain:		
What are your primary concerns in considering orthodontic treatment? (Please check all that apply)		
Correcting the bite: Cost: Ability to be treated with specific appliance (ie., Invisalign):		More attractive smile: How much time it will take:
Other:		
How familiar are you with orthodontic treatment?	If other, please explain:	
We want to make sure your appointment meets your needs. Do you like 1) a lot of information, 2) keep it short and sweet, or 3) somewhere in the middle?	If other, please explain:	

Acknowledgement of receipt of Privacy Policy: _____