Health History Form

Patient Biographical Information

*First Name:		*Birthdate:	
Middle Initial:		*Gender:	Male / Female
*Last Name:			
Nickname:			

*Address:		*Main Phone:	
*City:		2nd/Cell Phone:	
*State:		Email:	
*Zip:		Social Security #:	

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?

Financial Party Information

☐ **Check if the patient is also the person who will be financially responsible for treatment.**

*First Name:		*Address:	
Middle Initial:		*City:	
*Last Name:		*State:	
		*Zip:	

*Main Phone:		Social Security #:	
2nd/Cell Phone:		Employer:	
Email:		Occupation:	
Relationship to Patient: Father / Grandparent / Guardian / Mother / Parents / Self / Spouse / Step Father / Step Mother / Other		Length of Employment:	
		Work Phone:	

Do you have insurance that covers orthodontics? ○ No ○ Yes
If so, please name the Insurance Company below:

Dental History

Dentist Name:		Has the patient had an orthodontic consult or treatment? ○ No ○ Yes
Check-up Frequency: 1 per yr / 2 per yr / >2 per yr / Never / Emergency only		If so, when?
Last Dental Visit:		

What is the patients main orthodontic concern?

Please select YES if the patient has had any of the conditions listed below either now or in the past.

○ No ○ Yes	Speech problems/therapy?	○ No ○ Yes	Brush teeth daily?
○ No ○ Yes	Grind or clench teeth?	○ No ○ Yes	Floss teeth daily?
○ No ○ Yes	Oral habits (thumb/finger sucking, lip/nail biting)?	○ No ○ Yes	Fluoride treatments?
○ No ○ Yes	Injury to face, jaw, teeth or mouth?	○ No ○ Yes	Mouth breathing?
○ No ○ Yes	Discomfort from teeth or gums?	○ No ○ Yes	Snores during sleep?
○ No ○ Yes	Pain, tenderness or noise in either jaw?	○ No ○ Yes	Requires premedication?
○ No ○ Yes	Frequent headaches?	○ No ○ Yes	Any missing or extra permanent teeth?
○ No ○ Yes	Neck/shoulder pain?	○ No ○ Yes	Apprehensive about dental care?
○ No ○ Yes	Frequent sore throats?	○ No ○ Yes	Frequently Chew Gum?

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

Medical History

Physician Name:		Date of last Physical:	
Address:		Patient Health:	Excellent / Good / Fair / Poor
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 if the patient has had any of the conditions listed below either now or in the past.

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

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

Patients Under 18

If patient is under the age of 18, please answer the following questions:

Please list the name and birthdate of any siblings:

Height:		School:	
Weight:		Grade:	

Father/Guardian 1 Name:

Mother/Guardian 2 Name:

Has patient begun puberty:	No	Yes
If patient is a girl, has menstruation begun:	No	Yes
If patient is a boy, has their voice changed or have facial hair:	No	Yes
Has the patient grown in the past year or has their shoe size changed recently:	No	Yes

Signature: ____ Date: ______________________________