New Patient Health History

Patient Biographical Information			
Date:			
First Name:	Middle Initial:	Last Name:	Nickname:

Birthdate:	Gender:	Social Security #:

Address:	City:	State:	Zip:

Home Phone:	Work Phone:	Cell Phone:

Patient's 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?

Financial Party Information		
First Name:	Middle Initial:	Last Name:

Address:	City:	State:	Zip:

Length of time at above address:		
Home Phone:	Work Phone:	Cell Phone:
Social Security #:	Employer:	Occupation:
Length of Employment:	Work Phone:	Relationship to Patient:

Spouse's Name:	Spouse's Occupation:
Spouse's Work Phone:	Spouse's Cell Phone:

Parent's marital status: Married Separated Divorced Single Widowed

With whom does patient reside?	Legal Guardian:

If you have insurance that covers orthodontics – please complete:

Name of Insurance Company:	Group #:

Name of Policy Holder:	
Policy Holder Birthdate:	Subscriber ID#:

Second insurance that covers orthodontics – please complete:

Name of Insurance Company:	Group #:

Name of Policy Holder:	
Policy Holder Birthdate:	Subscriber ID#:

Dental History

Dentist Name:

Check-up Frequency: | Last Dental Cleaning:

Has the patient had an orthodontic consult or treatment? Yes No | If so, when?

What is the patient's main orthodontic concern?

Speech problems/therapy?	Yes	No	Brush teeth daily?	Yes	No
Grind or clench teeth at night or habitually?	Yes	No	Floss teeth daily?	Yes	No
Oral habits (thumb/finger habit, lip/nail biting)?	Yes	No	Use fluoride rinse daily?	Yes	No
Injury to face, jaw, teeth, or mouth?	Yes	No	Mouth breathing?	Yes	No
Discomfort from teeth or gums?	Yes	No	Snores during sleep?	Yes	No
Pain in or near your ears?	Yes	No	Antibiotic before dental treatment?	Yes	No
Frequent headaches?	Yes	No	Any missing or extra permanent teeth?	Yes	No
Neck/shoulder pain?	Yes	No	Apprehensive about dental care?	Yes	No
Frequent sore throats?	Yes	No	Frequently chews gum?	Yes	No
Constant sore or bleeding gums?	Yes	No	Had any teeth removed?	Yes	No
Difficulty chewing or swallowing food?	Yes	No	Clicking jaw joint when opening/closing?	Yes	No
			Pain or tenderness in either jaw?	Yes	No

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

Medical History

Physician Name: | Date of last Physical: | Patient Health:

Address: | City: | State: | Zip:

Is patient presently under a physician's care? If yes, please explain:

List any medications currently being taken by the patient:

List drug allergies, latex allergy, or sensitivity:

Rheumatic Fever	Yes	No	Received Radiation Treatment	Yes	No
Tuberculosis/Lung Disease	Yes	No	Growth Problems	Yes	No
Pneumonia	Yes	No	Endocrine Problems	Yes	No
Liver Disease	Yes	No	Hormone Therapy	Yes	No
Kidney Disease	Yes	No	Latex/Metal Allergy	Yes	No
Heart Attack/Stroke	Yes	No	Nervous Disorders	Yes	No
Heart Disease	Yes	No	Bone Disorders/Bone Loss	Yes	No
Congenital Heart Defect	Yes	No	Diabetes	Yes	No
Heart Murmur	Yes	No	Seizures/Epilepsy	Yes	No
Hemophilia	Yes	No	Handicaps/Disabilities	Yes	No
Hypertension/High Blood Pressure	Yes	No	Asthma	Yes	No
Prolonged Bleeding/Transfusion	Yes	No	Rheumatism or Arthritis	Yes	No
Anemia	Yes	No	Treated for Emotional Problems	Yes	No
HIV/AIDS	Yes	No	Ever Been Hospitalized	Yes	No
Hepatitis	Yes	No	Tonsils/Adenoids Removed	Yes	No
Stomach or Intestinal Disease	Yes	No	Operations or Injuries of Head or Neck	Yes	No
Yellow Jaundice or Hepatitis	Yes	No	History of fainting	Yes	No
Cancer	Yes	No	If female, are you pregnant	Yes	No
Family History of Cancer	Yes	No			

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

Are there any medical conditions we have not discussed that you feel we should be made aware of?

Patients Under 18					
Please list the name and birthdates of any siblings:					
Height:	Weight:	School:		Grade:	
Father/Guardian 1 Name:			Mother/Guardian 2 Name:		
Father/Guardian 1 Email:			Mother/Guardian 2 Email:		
Father's Height:			Mother's Height:		
Patient's Hobbies / Interests:					
Sports:					
Has patient begun puberty?				Yes No	
If patient is a girl, has menstruation begun?				Yes No	Age:
If patient is a boy, has their voice changed or have facial hair?				Yes No	
Has the patient experienced a sudden increase in height?				Yes No	
Does any member of the family or close relatives have similar arrangement of teeth or jaws?				Yes No	
Has any member of the family had orthodontic treatment?				Yes No	
			If yes, who/whom?	❑ Father	❑ Mother ❑ Sibling(s)
Who first noticed the need for orthodontic treatment?					
	❑ Parents	❑ Dentist	❑ Patient	Other:	
Are the parents interested in having orthodontic treatment:					
	❑ for appearance	❑ better digestion	❑ better speech	❑ advice of dentist	❑ advice of friends
Is the patient concerned about the appearance of his/her teeth?					Yes No
Has the patient ever been teased about the appearance of his/her teeth?					Yes No
Is the patient aware of/or concerned about his/her orthodontic problem?					Yes No
What is the patient's attitude toward wearing orthodontic appliances?					
	❑ Eagerness	❑ Willingness	❑ Complacency	❑ Resignation	❑ Antagonism

Signature: ______________________________ Date: ____________________

Doctor Signature: __________________________ Date Reviewed: ______________