New Patient Health History

Patient Biographical Information

First Name: _____ Middle Initial: _____ Last Name: _____ Date: _____

Nickname: _____ Birthdate: _____ Age: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Main Phone: _____ 2nd/Cell Phone: _____ Email: _____

School: _____ Grade: _____ Sports, hobbies, or instruments: _____

_____

Responsible/Financial Party Information

Parent/Guardian 1: ____Mother ____Father ____Step Parent ____Guardian Marital Status_____

First Name: _____ Middle Initial: ____ Last Name: _____Birthdate: _____

Do you have legal custody of this child?: _____ Address: _____ City: _____

State: _____ Zip: _____Main Phone: _____ Work/Cell Phone: _____

Email: _____ Employer: _____

Parent/Guardian 2: ____Mother ____Father ____Step Parent ____Guardian Marital Status_____

First Name: _____ Middle Initial: ____ Last Name: _____Birthdate: _____

Do you have legal custody of this child? : _____ Address: _____ City: _____

State: _____ Zip: _____Main Phone: _____ Work/Cell Phone: _____

Email: _____ Employer: _____

Insurance Information

Do you have insurance that covers orthodontics: Yes No If yes, what is the name of your insurance company? _____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____ Group / Plan #: _____ Member ID #: _____

Policy Owner's Name: _____ Relationship to Patient: _____ Policy Owner's Birthdate: _____

Policy Owner's Employer: _____ Employer's Address: _____

Dental History

Dentist Name: _____ Last Dental Visit: _____ Check-up Frequency: _____

Has the patient had an orthodontic consult or treatment: Yes No If yes, when? _____

What is the patient's main orthodontic concern? _____

Speech problems/therapy?	**Yes**	**No**	Grind or clench teeth?	**Yes**	**No**
Injury to face, jaw, or mouth?	**Yes**	**No**	Discomfort from teeth or gums?	**Yes**	**No**
Pain, tenderness, or noise in jaw joint(s)?	**Yes**	**No**	Frequent headaches?	**Yes**	**No**
Oral habits (thumb/finger sucking, lip/nail biting)?	**Yes**	**No**	Snores during sleep?	**Yes**	**No**
Frequent sore throats?	**Yes**	**No**	Mouth breathing?	**Yes**	**No**
Requires premedication?	**Yes**	**No**	Brush teeth daily?	**Yes**	**No**
Apprehensive about dental care?	**Yes**	**No**	Floss teeth daily?	**Yes**	**No**
Use tobacco/nicotine?	**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: _____

List any medications currently being taken by the patient: _____

List any drug allergies or sensitivities that the patient may have: _____

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

Ever taken Fosamax or taken any other bisphosphonate? Yes No If yes, when _____

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

_____

Whom may we thank for referring you to our practice? _____

Please list the names and ages of any siblings: _____

Patients under 18

Has the patient grown in the past year or has their shoe size changed recently?	**Yes**	**No**
Has either biological parent ever had orthodontic treatment?	**Yes**	**No**
If so, did parent's treatment require Jaw Surgery?	**Yes**	**No**

Patient's interest in treatment? _____

The Parent or Guardian who accompanies the child is responsible for payment.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: _____Print: _____ Date: _____

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I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: Initials: _____ Date: _____