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For Children & Adults

# ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

PLEASE PRINT

## PATIENT INFORMATION

Date ___________________________

Name_____________________________________________________________________________
(First) (Middle) (Last) (Nickname)

Address ________________________________________________ Phone ____________________
(Street) (City) (State, Zip)

Male ☐ Female ☐ Age __________ Date of Birth________________________________

School ___________________________ Grade _______ Hobbies ___________________________

Siblings (Age) ____________ ( ) ______________ ( ) ______________ ( ) ______________ ( )

Dentist Name___________________________ Physician Name___________________________

## FINANCIALLY RESPONSIBLE PARTY

Name (Dr. Mr. Mrs. Ms.)_____________________________________ Date of Birth _______________

Single ☐ Married ☐ Separated ☐ Divorced ☐

Address (if different from above) _____________________________________________________
(Street) (City) (State, Zip)

Home Phone_____________________________ Cell Phone_____________________________

Email __________________________________ Fax________________________________

Employer ______________________ Soc. Sec. #____________________ Bus. Phone_________________
(Father)

Employer ______________________ Soc. Sec. #____________________ Bus. Phone_________________
(Mother)

Orthodontic insurance coverage? Yes ☐ No ☐

Primary insurance company___________________________ Policy # or Name___________________________

Secondary insurance company_________________________ Policy # or Name___________________________

Relatives treated at our office __________________________________________________________

Whom may we thank for referring you to our office?________________________________________

Person completing this form______________________________ Relationship to patient_____________________

PLEASE NOTE TO UPDATE OUR OFFICE REGARDING ANY CHANGES IN YOUR INSURANCE STATUS

PLEASE TURN OVER FOR HEALTH HISTORY

## DENTAL HISTORY

Approximate date of last dental visit ___________________

Do you have or have ever had any of the following conditions?

| | Yes | No |
|---|---|---|
| Dental caries (cavities) | Y | N |
| Gingivitis (swollen gums) | Y | N |
| Periodontal (gum) disease | Y | N |
| Dental trauma | Y | N |
| Tooth sensitivity to hot/cold/sweets | Y | N |
| Finger or thumb sucking (Until age____) | Y | N |
| Lip biting or sucking (Until age____) | Y | N |
| Bruxism (grinding of teeth) | Y | N |
| Difficulty chewing and/or swallowing | Y | N |
| Frequent sore/strep throat or tonsillitis | Y | N |
| Middle ear infections | Y | N |
| Jaw joint pain and/or facial pain | Y | N |
| Jaw joint noises (clicking, popping, grinding) | Y | N |
| Injury to jaw, face, head or neck | Y | N |
| Difficulty opening/closing your mouth | Y | N |
| Previous TMJ treatment (jaw joint disorder) | Y | N |

Have you had any orthodontic treatment in the past? Y N

If yes, when___________________________________________

Have you had any problems associated with previous dental treatment? Y N

If yes, please explain___________________________________________

What is (are) your main concern(s) regarding your teeth?___________________________________________

## MEDICAL HISTORY

Patient's height __________ Patient's weight ___________ Approximate date of last physical exam ___________

Do you have or have ever had any of the following diseases or conditions?

| | Yes | No |
|---|---|---|
| Heart problems | Y | N |
| Heart murmur or valve defect | Y | N |
| Rheumatic fever/heart disease | Y | N |
| Congenital heart lesions | Y | N |
| Cardiovascular disease | Y | N |
| Prosthetic valve replacement or repair | Y | N |
| Joint replacement | Y | N |
| High or low blood pressure | Y | N |
| Anemia or blood disorder | Y | N |
| Prolonged bleeding | Y | N |
| Cancer/radiation therapy | Y | N |
| Hepatitis, jaundice or liver problems | Y | N |
| Kidney trouble | Y | N |
| Stomach problems/ulcers | Y | N |
| Epilepsy, seizures, convulsions | Y | N |
| Diabetes | Y | N |
| Asthma | Y | N |
| Hay fever, allergies or sinus problems | Y | N |
| Arthritis | Y | N |
| Rheumatism (painful swollen joints) | Y | N |
| Endocrine problem (thyroid or pituitary) | Y | N |
| Tuberculosis | Y | N |
| Bone disorder | Y | N |
| Venereal/sexually transmitted disease | Y | N |
| AIDS, ARC, OR HIV positive | Y | N |
| Females only: Are you pregnant? | Y | N |

Are you in good health? Y N

If a child: Has the child reached puberty? Y N

Are you currently under the care of a physician? Y N

If yes, what condition(s) is (are) being treated? ___________________________________________

Has there been any change in your general health within the last year? Y N

If yes, what was/is the problem? ___________________________________________

Have you been hospitalized or had a serious illness in the past five years? Y N

If yes, what was the problem? ___________________________________________

Are you taking any drugs or medications? Y N

If yes, please list ___________________________________________

Are you allergic to or have you had any adverse reactions to any drugs or medications? Y N

If yes, please list ___________________________________________

Have you ever been told by your physician or dentist to take antibiotics before dental treatment? Y N

Do you have any disease, condition, or problem not listed that we should know about? Y N

If yes, please explain ___________________________________________

PLEASE NOTE TO UPDATE OUR OFFICE REGARDING ANY CHANGES TO YOUR MEDICAL STATUS