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:			
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:	Policy Holder SS or 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		Premedication 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:			
Does patient play a musical instrument with his/her mouth?		If yes, please list all:	

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	Cancer	Yes	No
Tuberculosis/Lung Disease	Yes	No	Family History of Cancer	Yes	No
Pneumonia	Yes	No	Received Radiation Treatment	Yes	No
Liver Disease	Yes	No	Growth Problems	Yes	No
Kidney Disease	Yes	No	Endocrine Problems	Yes	No
Heart Attack/Stroke	Yes	No	Hormone Therapy	Yes	No
Heart Disease	Yes	No	Latex/Metal Allergy	Yes	No
Congenital Heart Defect	Yes	No	Nervous Disorders	Yes	No
Heart Murmur	Yes	No	Bone Disorders/Bone Loss	Yes	No
Hemophilia	Yes	No	Diabetes	Yes	No
Hypertension/High Blood Pressure	Yes	No	Seizures/Epilepsy	Yes	No
Prolonged Bleeding/Transfusion	Yes	No	Handicaps/Disabilities	Yes	No
Anemia	Yes	No	Asthma	Yes	No
HIV/AIDS	Yes	No	Rheumatism or Arthritis	Yes	No
Hepatitis	Yes	No	Treated for Emotional Problems	Yes	No
Venereal Disease	Yes	No	Ever Been Hospitalized	Yes	No
Blood Disease	Yes	No	Ever Had Extensive X-ray Therapy	Yes	No
Tumors or Growths	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
Night Sweats accompanied by weight loss/cough	Yes	No	Currently dieting	Yes	No
Wounds heal slowly / present complications	Yes	No	If female, are you pregnant	Yes	No

Other, if so, please explain?

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

Has patient been ill for more than 5 days in the last year? If yes, please explain:

Allergic to any known materials resulting in hives, asthma, eczema, etc? If yes, please explain:

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

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

Are the parents aware that some appointments may infringe minimally on school time? Yes No

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: _____