Health History

Patient Name ______________________ Date ______________________

Patient's Birthdate ______________________ Family Dentist ______________________

Family Physician ______________________

Please check all that apply

Dental History

Yes

- ❑ Has patient ever sucked their thumb or finger?
- ❑ Does patient suck thumb or finger now?
- ❑ Does patient have any speech problems or therapy?
- ❑ Does patient have any difficulty chewing food?
- ❑ Does patient have any difficulty breathing through their nose?
- ❑ Does patient grind or clench teeth at night?
- ❑ Does patient have bleeding gums?
- ❑ Has patient ever had injury or surgery to head or neck area?
- ❑ Does patient have any clicking or popping when opening mouth?
- ❑ Does patient have pain in the jaws?
- ❑ Has patient had a prior orthodontic examination or treatment?

Medical History

Has patient had or have any of the following?

Yes

- ❑ Reaction to any medications List if any ______________________
- ❑ Allergies List if any ______________________
- ❑ Diabetes
- ❑ Arthritis
- ❑ Asthma
- ❑ Epilepsy
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ Nervous Disorders
- ❑ Anemia
- ❑ Heart disease or Heart problems
- ❑ Rheumatic Fever
- ❑ AIDS
- ❑ HIV+
- ❑ Dizziness or Fainting
- ❑ Frequent Headaches
- ❑ Bone Disorders
- ❑ Tonsils or Adenoids removed
- ❑ Does patient have any other medical conditions not mentioned above? List ______________________

  ____
- ❑ Is patient taking any medications? List ______________________

Please inform us if any changes occur to the patient's medical history.

A B C

Patient Information

Date ______________________

Patient's Name ____
Last | First | Middle

Address ____
Street | City | State | Zip

Home Phone ______________ Birthdate ______________ Social Security # ______________

If patient is a minor, give parent's or guardian's name ______________________________

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

Responsible Party Infomation

Name ____
Last | First | Middle | Marital Status

Residence ____
Street | City | State | Zip

Mailing Address ____
Street | City | State | Zip

How long at this address? ______________ Home Phone ______________ Work Phone ______________

Previous Address (if less than 3 yrs.) ____
Street | City | State | Zip

Social Security # ______________ Birthdate ______________ Relationship to Patient ______________

Employer ______________ Occupation ______________ No. Years Employed ______________

Spouse's Name ______________________________ Relationship to Patient ______________
Last | First | Middle

Employer ______________ Occupation ______________ No. Years Employed ______________

Social Security # ______________ Birthdate ______________ Work Phone ______________

Insurance Information

Insured's Name ______________________________ Insured's Soc. Sec. # ______________

Insurance Company ______________________________ Group No. ______________ Local No. ______________

Insurance Co. Address ____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name ______________________________ Insured's Soc. Sec.#. ______________

Insurance Co. ______________________________ Group No. ______________ Local No. ______________

Insurance Co. Address ____

Authorization - Assignment of Benefits ____

Emergency Information

Name of nearest relative not living with you ______________________________

Complete Address ____

Phone ______________________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ______________________________

Updated (date & initial) ______________________________