ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY
Welcome to our office! Please fill out both pages of this form

TELL US ABOUT YOURSELF

Name: ____________________________ Prefers to be called: ___________ Age: ____ Birth Date: ________ Sex: _____

Address: ____ Phone (home): ____________________________________

____ Phone (cell): ____________________________________

Email Address: ___________________________________ Phone (work): ____________________________________

Who may we thank for referring you to our office: ____

MEDICAL HISTORY

Name of Patient's Physician: ____________________________________ City: ___________________________________

Are you in good health at this time: Y [ ] N [ ]

Are you under the care of a physician for an illness? Y [ ] N [ ] If yes, please explain: ______________________

Are you taking any medications? Y[ ] N [ ] Name and for what condition: ______________________________

Do you have any allergies? Y[ ] N[ ] If yes, please specify allergy: __________________________________

Do you have or have a history of any of the following conditions? Please check all that apply

___ Abnormal Bleeding	___ Cold Sores	___ Headaches/migraines	___ Kidney/Liver Disease
___ Arthritis	___ Diabetes	___ Heart condition/murmur	___ Previous surgery
___ Artificial joint/valve	___ Dizziness/fainting	___ Head/face injury	___ Rheumatic fever
___ Asthma	___ Emotional problems	___ Hepatitis	___ Sinus problems
___ Birth/congenital defects	___ Endocrine problems	___ Herpes	___ Thyroid problems
___ Cancer	___ Epilepsy/seizures	___ HIV Positive	___ Tuberculosis

Please explain any of the above checked or any conditions not listed:

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Do you require antibiotics prior to dental procedures? Y [ ] N [ ]

Have you ever been hospitalized or had a serious illness or injury? Y [ ] N [ ]

If yes, please explain: ____

Females, does the possibility of pregnancy exist? Y [ ] N [ ]

DENTAL HISTORY

Name of your dentist: ________________________________ City: _________________ Date of last visit: _____________

Why are you seeking an orthodontic consultation? ____

Does anyone in your family have a similar dental condition for which you are seeking treatment? Y [ ] N [ ]

Have you had a previous orthodontic consultation? Y [ ] N [ ] or orthodontic treatment? Y [ ] N [ ]

Date: ___________________ Doctor: _____________________________ City: _____________________________

Have other family members had orthodontic treatment? Y [ ] N [ ] Are you satisfied with the results? Y [ ] N [ ]

Have you ever sucked your finger, thumb, or pacifier? Y [ ] N [ ] If yes, when did this habit stop? _____________

Do you have any facial or jaw pain, clicking, or popping of the jaw joint? Y [ ] N [ ]

Do you grind or clench your teeth? Y [ ] N [ ]

Do you have or have a history of difficulty opening your mouth? Y [ ] N [ ]

Have you ever had your jaw lock open or closed? Y [ ] N [ ]

BILLING INFORMATION

Financially Responsible Party:

Name: ____ Relationship to patient: _________________________

Address: __________________________________ City: ___________________ State: ____________ Zip:_____________

Phone: Home: _________________ Work: _________________ Cell: _________________ Soc.Sec.#: ________________

Primary Dental Insurance Information:

Subscribers Name: ____________________________ Social Security #: ______________________ Birth Date: __________

Insurance Company: __________________________ Group #: __________________ Enrollee ID #: __________________

Employer Name: ____ Insurance Phone #: __________________________

Secondary Dental Insurance Information:

Subscribers Name: ____________________________ Social Security #: ______________________ Birth Date: __________

Insurance Company: __________________________ Group #: __________________ Enrollee ID #: __________________

Employer Name: ____ Insurance Phone #: __________________________

Signature: ____ Date: _______________

Update Signature: _______________________________________ Date: _______________

Update Signature: _______________________________________ Date: _______________