New Patient Health History

Confidential Patient Information	
First Name	Birth date
Middle Initial	Gender
Last Name	
Nickname	
Address	Main Phone
City	2nd / Cell Phone
State	Email
Zip	Social Security #
Parent or Guardian Name	
Who does patient live with	
Family or Friends seen	
Sports, Hobbies or Music instrument	
Who referred you	

Confidential Financial Party Information			
Responsible Party			
First Name:		Address:	
Middle Initial		City:	
Last Name:		State:	
Marital Status:		Zip	
How long at address:		Previous Address:	
Main Phone:		Social Security #	
2nd/Cell Phone:		Employer:	
E-mail:		Occupation:	
Birth date:		Length of Employment:	
Relationship to Patient:		Work Phone #	
Spouse Information			
First Name:		Occupation	
Middle Initial		Birth date:	
Last Name:		Length of Employment:	
Social Security #		Work Phone #	
Employer		Relationship to Patient:	

Dental Insurance Information			
Primary Dental Insurance			
Policy Holder's Name:		Subscriber ID#:	
Insurance Company:		Group #:	
Address:		Phone #:	
City:		Employer:	
State:		Relationship to Patient:	
Zip:			
Dual Dental Coverage:			
Secondary Dental Insurance			
Policy Holder's Name:		Subscriber ID#:	
Insurance Company:		Group #:	
Address:		Phone #:	
City:		Employer:	
State:		Relationship to Patient:	
Zip:			

Emergency Information	
Nearest relative not living with you:	
Complete Address:	

Phone:		Relationship to Patient:	

Dental History			
Dentist Name:		Ever had consult / treatment:	
Check up Frequency:		If so, when	
Last Dental Visit:			
Premedicate prior to dental visit			
Main orthodontic concern:			

Speech problems/therapy?		Brush teeth daily?	
Grind or clench teeth?		Floss teeth daily?	
Oral habits (thumb/finger habit, lip/nail biting)?		Fluoride treatments?	
Injury to face, jaw, teeth, or mouth?		Mouth breathing?	
Discomfort from teeth or gums?		Snores during sleep?	
Pain, tenderness, or noise in either jaw?		Any missing or extra permanent teeth?	
Frequent headaches?		Apprehensive about dental care?	
Neck/shoulder pain?		Frequently chews gum?	
Frequent sore throats?		Thumb or finger habit as a child	
Chipped or injured permanent teeth		Jaw fractures, cysts, mouth infections	
Teeth sensitive to hot or cold		Bleeding gums	
Previous root canal therapy		Other periodontal (gum) problems	
Bad taste/mouth odor		Frequent canker sores or cold sores	
Previous periodontal (gum) treatment		Have wisdom teeth been removed	
Abnormal swallowing (tongue thrust)		Problems with food trapped between teeth	
Teeth that irritate tongue, cheek, lip, etc		Is all dental work completed at this time	
Numerous fillings			
Explain any “Yes”:			

Had a TMJ screening		Experience soreness in the muscles of face or around ears	
History of jaw joint problems		Notice clicking or popping in jaw joint	
Have you been treated for “TMJ”		Do you clench your teeth	
Has jaw ever locked		Difficulty chewing or opening mouth	
Does bite feel uncomfortable or unusual			
Explain any “Yes”:			

Medical History			
Physician Name:		Date of last physical:	
Address:		Patient Health:	
City, State Zip			
Any changes in patient’s general health within the last year			
Is patient under care of a physician			
If so, what is being treated			
Has patient had a serious illness/hospitalization in past 5 years			
If so, for what			
Medications taken			
Allergies or drug reactions to			
Latex		Penicillin or other antibiotics	
Sulfa Drugs		Aspirin, Ibuprofen, Tylenol	
Local anesthetics		Codeine or other narcotics	
Other		Local anesthetics	
Drug allergies or sensitivities			

Heart Murmur	Diabetes
Damaged or artificial heart valves	Growth Problems
Congenital Heart Defect	Tuberculosis/Lung Disease
Heart Disease	Pneumonia
Rheumatic Fever	Cancer
Angina	Family History of Cancer
Liver Disease / Jaundice / Hepatitis	Received Radiation Treatment
Kidney Disease	Arteriosclerosis
Heart Attack/Stroke	Thyroid / Endocrine Problems
Hemophilia	Stomach ulcer or hyperacidity

Hypertension/High Blood Pressure	Hormone Therapy
Prolonged Bleeding/Transfusion	Metal Allergy
Anemia / Blood disorder	Nervous Disorders
HIV/AIDS	Bone Disorders/Bone Loss
Tonsils/Adenoids Removed	Seizures/Epilepsy
Handicaps/Disabilities	Seizures / Epilepsy / Neurological Disease
Arthritis / Joint problems	Asthma
Large Tonsils	Respiratory problems / Emphysema
Sinus trouble	Persistent swollen neck glands
Bed wetting	Sexually transmitted disease
Substance abuse problem (past or present)	Low blood pressure
Bone fractures / trauma to face / jaw	Persistent cough
Prosthetic joints	FEMALES: Pregnant
Chronic fatigue	Take Bisphosphonates (Fosamax, Boniva)
Explain any “Yes”	

Patient Motivation for Orthodontic Treatment	
How would you change your teeth	
How would you change your facial appearance	
Where would you like to reduce the pain or discomfort	

Patients Under 18			
Height:		School:	
Weight:		Grade:	
Has patient begun puberty			
If girl, has menstruation begun			
If boy, has voice changed or have facial hair			
Has the patient grown in the past year or has their shoe size changed recently			
Has either biological parent ever had orthodontic treatment?			
	I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.		
	I understand that where appropriate, credit bureau reports may be obtained.		

Date