New Patient Health History

Patient Biographical Information				
First Name:	Middle Initial:	Last Name:		
Nickname:	Birthdate:		Gender:	
Address:	City:	State:	Zip:	
Main Phone:	2nd/Cell Phone:		Email:	
Social Security #:				
Please list the names of any friends or family currently in the practice:				
List any sports, hobbies, or musical instruments played:				
Whom may we thank for referring you to our practice?				

Financial Party Information			
First Name:	Middle Initial:	Last Name:	
Birthdate:	Relationship to Patient:	Email:	
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Social Security #:	
Employer:	Occupation:	Length of Employment:	
Work Phone:			
Do you have insurance that covers orthodontics? Yes No	If so, please name the Insurance Company:		

Dental History			
Dentist Name:			
Check-up Frequency:		Last Dental Visit:	
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		Grind or clench teeth? Yes No	
Injury to face, jaw, teeth or mouth? Yes No		Discomfort from teeth or gums? Yes No	
Pain, tenderness or noise in either jaw? Yes No		Frequent headaches? Yes No	
Oral Habits (thumb/finger sucking, lip/nail biting)? Yes No		Neck/shoulder pain? Yes No	
Frequent sore throats? Yes No		Brush teeth daily? Yes No	
Floss teeth daily? Yes No		Fluoride treatments? Yes No	
Mouth Breathing? Yes No		Snores during sleep? Yes No	
Requires premedication? Yes No		Any missing or extra permanent teeth? Yes No	
Apprehensive about dental care? Yes No		Frequently chew gum? Yes No	
If any of the above dental questions were answered "Yes," please explain:			

Medical History							
Physician Name:		Date of last Physical:			Patient Health:		
Address:		City:		State:		Zip:	
List any medications currently being taken by the patient:							
List any drug allergies or sensitivities that the patient may have:							
Rheumatic Fever	Yes No			Tuberculosis/Lung Disease	Yes No		
Pneumonia	Yes No			Liver Disease	Yes No		
Kidney Disease	Yes No			Heart Attack/Stroke	Yes No		
Heart Disease	Yes No			Congenital Heart Defect	Yes No		
Heart Murmur	Yes No			Hemophilia	Yes No		
Hypertension/High Blood Pressure	Yes No			Prolonged Bleeding/Transfusion	Yes No		
Anemia	Yes No			HIV/AIDS	Yes No		
Hepatitis	Yes No			Tonsils/Adenoids Removed	Yes No		
Cancer	Yes No			Family History of Cancer	Yes No		
Received Radiation Treatment	Yes No			Growth Problems	Yes No		
Endocrine Problems	Yes No			Hormone Therapy	Yes No		
Latex/Metal Allergy	Yes No			Nervous Disorders	Yes No		
Bone Disorders/Bone Loss	Yes No			Diabetes	Yes No		
Seizures/Epilepsy	Yes No			Handicaps/Disabilities	Yes No		
Asthma	Yes No			Arthritis	Yes No		
Treated for Emotional Problems	Yes No			Ever Been Hospitalized	Yes No		
If any of the above medical questions were answered “Yes,” please explain:							

Patients Under 18			
Please list the name and birth date of any siblings:			
Height:	Weight:	School:	Grade:
Father/Guardian 1 Name:		Mother/Guardian 2 Name:	
Has patient begun puberty?		Yes No	
If patient is a girl, has menstruation begun?		Yes No	
If patient is a boy, has their voice changed or have facial hair?		Yes No	
Has the patient grown in the past year or has their shoe size changed recently?		Yes No	
Patient’s interest in treatment?			
Has either biological parent ever had orthodontic treatment?		Yes No	

Signature: _____ Date: _____