New Patient Health History

Patient Biographical Information			
First Name:	Middle Initial:	Last Name:	Nickname:
Birth date:	Gender:	Social Security #:	
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Email:	
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:	
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Email:	
Social Security #:	Employer:	Occupation:	
Length of Employment:	Work Phone:	Relationship to Patient:	
Do you have insurance that covers orthodontics?	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?			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?	Yes	No	Floss teeth daily?	Yes	No
Oral habits (thumb/finger habit, lip/nail biting)?	Yes	No	Fluoride treatments?	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, tenderness, or noise in either jaw?	Yes	No	Requires premedication?	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
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	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	Arthritis			Yes	No
Hepatitis	Yes	No	Treated for Emotional Problems			Yes	No
Tonsils/Adenoids Removed	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?						Yes	No
Has either biological parent ever had orthodontic treatment?						Yes	No

Signature: _____ Date: _____