



## Patient Health History Form

### Patient

Date: \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_  
 Patient's first name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Sex:  Male  Female Social Security Number # \_\_\_\_\_  
 Hobbies, activities: \_\_\_\_\_  
 Home address: \_\_\_\_\_ City, State, Zip code: \_\_\_\_\_  
 Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Email address(es): \_\_\_\_\_

### Parent/Guardian

Custodial parent(s) name (s): \_\_\_\_\_  
 Patient lives with (mark all that apply)  Mother  Father  Stepmother  Stepfather  Grandparent(s)  Other

### Dentist

Patient's dentist: \_\_\_\_\_ Address, City, State: \_\_\_\_\_  
 Last seen: \_\_\_\_\_ Reason: \_\_\_\_\_ Next appointment: \_\_\_\_\_  
 Other dentists/ dental specialists now being seen: Name: \_\_\_\_\_ City, State: \_\_\_\_\_

### General Information

What concerns do you have about your teeth? \_\_\_\_\_  
 Have any other family members been treated in this office? \_\_\_\_\_ If yes, please name them: \_\_\_\_\_  
 Have you had any previous orthodontic treatment? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_  
 Why did you select our office? \_\_\_\_\_

### Dental Insurance

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Primary policy holder's full name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Member or Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Relationship Patient: \_\_\_\_\_

Policy Holders Address: \_\_\_\_\_ City, State, Zip code: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
 Does this policy have orthodontics benefits?  YES  NO  I don't know

Secondary Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Secondary policy holder's full name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Member or Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Relationship Patient: \_\_\_\_\_

Policy Holders Address: \_\_\_\_\_ City, State, Zip code: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
 Does this policy have orthodontics benefits?  YES  NO  I don't know

**Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. For the following questions mark "yes", "no", or "not sure".**

## Medical history

### Now or in the past, have you had:

- |                              |                             |                                   |  |
|------------------------------|-----------------------------|-----------------------------------|--|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Birth defects or hereditary problems?                |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Bone fractures, or major injuries?                   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Any injuries to face, head or neck?                  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Arthritis or joint problems?                         |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Cancer, tumor, radiation treatment or chemotherapy?  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | AIDS or HIV positive?                                |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Hepatitis, jaundice or other liver problem?          |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Polio, mononucleosis, tuberculosis, pneumonia?       |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Seizures, fainting spells, neurologic problem?       |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Vision, hearing, or speech problems?                 |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | History of eating disorder (anorexia, bulimia)?      |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | High or low blood pressure?                          |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Excessive bleeding or bruising, anemia?              |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Heart defects, heart murmur, rheumatic heart disease |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Angina, arteriosclerosis, stroke or heart attack?    |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Frequent headaches or migraines?                     |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Frequent ear infections, colds, throat infections?   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Do you frequently breathe through your mouth?        |

### Have you had allergies or reactions to any of the following:

- |                              |                             |                                   |   |
|------------------------------|-----------------------------|-----------------------------------|---|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Latex (gloves, balloons)                            |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Metals (jewelry, clothing snaps)                    |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Acrylics  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Local anesthetics (Novocaine, lidocaine, xylocaine) |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Aspirin   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Ibuprofen (Motrin, Advil)                           |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Penicillin  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Other antibiotics                                   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Plant pollens                                       |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Animals   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Foods   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Other substances                                    |

## Dental History

### Now or in the past have you had:

- |                              |                             |                                   |   |
|------------------------------|-----------------------------|-----------------------------------|---|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Permanent or extra (supernumerary) teeth removed?         |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Supernumerary (extra) or congenitally missing teeth?      |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Chipped or injuries primary or permanent teeth?           |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Any sensitive or sore teeth?                              |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Bleeding gums, bad taste, or mouth odor?                  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Jaw fractures, cysts, infections?                         |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Any teeth treated with root canals or pulpotomies?        |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | History of speech problems or speech therapy?             |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Food impaction between teeth?                             |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Mouth breathing habit or snoring at night?                |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Frequent oral habits (sucking finger, chewing pen, etc.)? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Teeth causing irritation to lip, cheek or gums?           |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Abnormal swallowing (tongue thrust)?                      |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Tooth grinding or clenching?                              |

<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Clicking, locking in jaw joints?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Soreness in jaw muscles or face muscles?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Ringling in ears, difficulty in chewing or opening jaw?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Have you ever been diagnosed with gum disease or pyorrhea?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Have you ever had an orthodontic consultation or treatment before

**Patient Health Information**

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take: \_\_\_\_\_

Do you take antibiotic pre-medication before any dental procedures?  YES  NO

Have you smoked any substance or vaped?  YES  NO If yes, what is the frequency? \_\_\_\_\_

Have you chewed tobacco  YES  NO Have you noticed any changes in your face or jaws? \_\_\_\_\_

Any other physical problems? \_\_\_\_\_

How often do you brush?: \_\_\_\_\_ How often do you floss?: \_\_\_\_\_

Women: Are you pregnant?  YES  NO Are you trying to become pregnant?  YES  NO

**Release and Waiver**

I authorize release of any information regarding my orthodontics treatment to my dental and/ or medical insurance company.

I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_