



## New Patient Health History

Patient Biographical Information			
First Name:	Middle Initial:	Last Name:	
Nickname:	Birthdate:	Gender:	
Address:	City:	State:	Zip:
Main Phone:	2 <sup>nd</sup> /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:	2 <sup>nd</sup> /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	

Patient / Parent Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient (self, parent, etc): \_\_\_\_\_

Treatment Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_