

Welcome to our office! We care about your total health and appreciate your time in completing this health history

Patient Information

Patients Name _____ Nickname _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ SS# _____ - _____ - _____

If patient is a minor, parent's or guardian's name _____

School _____ Grade _____

How did you hear about us? _____

Siblings/Children Names and Ages _____

Responsible Party Information

Name _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address? _____ Own _____ Rent _____ Home phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ - _____ - _____ Birth date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. of years _____

Spouse's Name _____ Birthdate _____

Spouse's Employer _____ Occupation _____ No. of years _____

Spouse' Social Security # _____ Work Phone _____

Orthodontic Insurance Information

Insured's Name _____ Insured's SS# _____ - _____ - _____

Insured's Employer _____

Insurance Company _____ Group # _____ Local # _____

Insurance co. Address _____ Phone _____

Do you have dual coverage yes no if yes then:

Insured's Name _____ SS# _____ Employer _____

I hereby authorize payment directly to the above named orthodontist of the group insurance benefits otherwise payable to me.

Primary Insurance Company _____ Date _____ Signature _____ Date _____

Secondary Insurance Company _____ Date _____

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Effective date _____ Wait periods _____ Lifetime max _____

% _____ Deductibles _____ Age limits _____

This information is accurate and I understand where appropriate credit reports may be obtained

Signature _____ Date _____

Reviewed with patient by _____

Date _____

Medical History

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle yes or no. If yes please detail.

yes no Are you currently taking medication? _____

yes no Are you allergic to any medications? _____

yes no Do you have a history of a major illness? _____

yes no Have you had any major operations? _____

yes no Have you been involved in a serious accident? _____

yes no Have you ever been told to pre-medicate before dental appointments? _____

Circle any of the medical conditions below that you have had or currently have

Abnormal bleeding	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay-fever	GI Disorders	HIV+	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous disorder	Tumor or Cancer

Are there any medical problems that we should be aware of that are not listed here? _____

Dental History

Dentist _____ Date of last visit _____

Address _____ Phone _____

yes no Are you in dental pain? _____

yes no Have you ever lost or chipped any teeth? _____

yes no Have there been injuries to your head/face? _____

yes no Do your gums bleed when you brush/floss? _____

yes no Do you have a tongue or thumb habit? _____

yes no Have you ever been treated by an orthodontist? _____

Yes no Has anyone in your family been treated by an orthodontist? _____

yes no Are you aware of you jaw clicking or popping? _____

yes no Do you clench or grind your teeth? _____

yes no Do you have a history of headaches? _____