



## 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 medical 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	Ringing 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: \_\_\_\_\_