New Patient Health History

Confidential Patient Information	
First Name	Birth date
Middle Initial	Gender
Last Name	
Nickname	
Address	Main Phone
City	2nd / Cell Phone
State	Email
Zip	Social Security #
Parent or Guardian	
Who does patient live with	
Family or Friends seen	
Sports, Hobbies or Music instrument	
Who referred you	

Confidential Financial Party Information			
Responsible Party			
First Name: Middle Initial Last Name: Marital Status: How long at address: Main Phone: 2nd/Cell Phone: E-mail: Birth date: Relationship to Patient:		Address: City: State: Zip Previous Address: Social Security # Employer: Occupation: Length of Employment: Work Phone #	
Spouse Information			
First Name:		Occupation	
Middle Initial		Birth date:	
Last Name:		Length of Employment:	
Social Security #		Work Phone #	
Employer		Relationship to Patient:	

Dental Insurance Information			
Primary Dental Insurance			
Policy Holder's Name: Insurance Company: Address: City: State:		Subscriber ID#: Group #: Phone #: Employer: Relationship to Patient:	
Zip:			
Dual Dental Coverage:			
Secondary Dental Insurance			
Policy Holder's Name: Insurance Company: Address: City: State:		Subscriber ID#: Group #: Phone #: Employer: Relationship to Patient:	
Zip:			

Emergency Information			
Nearest relative not living with you: Complete Address:			
Phone:		Relationship to Patient:	

Dental History			
Dentist Name: Checkup Frequency:		Ever had consult / treatment: If so, when	
Last Dental Visit:			
Premedicate prior to dental visit Y N			
Main orthodontic concern:			
Speech problems/therapy?	Y N	Brush teeth daily?	Y N
Grind or clench teeth?	Y N	Floss teeth daily?	Y N
Oral habits (thumb/finger habit, lip/nail biting)?	Y N	Fluoride treatments?	Y N
Injury to face, jaw, teeth, or mouth?	Y N	Mouth breathing?	Y N
Discomfort from teeth or gums?	Y N	Snores during sleep?	Y N
Pain, tenderness, or noise in either jaw?	Y N	Any missing or extra permanent teeth?	Y N
Frequent headaches?	Y N	Apprehensive about dental care?	Y N
Neck/shoulder pain?	Y N	Frequently chews gum?	Y N
Frequent sore throats?	Y N	Thumb or finger habit as a child	Y N

Chipped/injured permanent teeth	Y N	Jaw fractures or cysts	Y N
Teeth sensitive to hot or cold	Y N	Bleeding gums	Y N
Previous root canal therapy	Y N	Other periodontal (gum) problems	Y N
Bad taste/mouth odor	Y N	Frequent canker sores or cold sores	Y N
Previous periodontal (gum) treatment	Y N	Have wisdom teeth been removed	Y N
Abnormal swallowing (tongue thrust)	Y N	Problems with food trapped between teeth	Y N
Teeth that irritate tongue, cheek, lip, etc	Y N	Is all dental work completed at this time	Y N
Numerous fillings			
Explain any “Yes”:			

Had a TMJ screening	Y N	Experience soreness in the muscles of face or around ears	Y N
History of jaw joint problems	Y N	Notice clicking or popping in jaw joint	Y N
Have you been treated for “TMJ”	Y N	Do you clench your teeth	Y N
Has jaw ever locked	Y N	Difficulty chewing or opening mouth	Y N
Does bite feel uncomfortable or unusual	Y N		
Explain any “Yes”:			

Medical History			
Physician Name: Address:		Date of last physical: Patient Health:	
City, State Zip			
Any changes in patient’s general health within the last year			
Is patient under care of a physician			
If so, what is being treated			
Has patient had a serious illness/hospitalization in past 5 years			
If so, for what			
Medications taken			
Allergies or drug reactions to:			
Latex	Y N	Penicillin or other antibiotics	Y N
Sulfa Drugs	Y N	Aspirin, Ibuprofen, Tylenol	Y N
Local anesthetics	Y N	Codeine or other narcotics	Y N
Other		Local anesthetics	Y N
Drug allergies:			

Heart Murmur	Y N	Diabetes	Y N
Damaged or artificial heart valves	Y N	Growth Problems	Y N
Congenital Heart Defect	Y N	Tuberculosis/Lung Disease	Y N

Heart Disease	Y N	Pneumonia	Y N
Rheumatic Fever	Y N	Cancer	Y N
Angina	Y N	Family History of Cancer	Y N
Liver Disease / Jaundice / Hepatitis	Y N	Received Radiation Treatment	Y N
Kidney Disease	Y N	Arteriosclerosis	Y N
Heart Attack/Stroke	Y N	Thyroid / Endocrine Problems	Y N
Hemophilia	Y N	Stomach ulcer or hyperacidity	Y N
Hypertension/High Blood Pressure	Y N	Hormone Therapy	Y N
Prolonged Bleeding/Transfusion	Y N	Metal Allergy	Y N
Anemia / Blood disorder	Y N	Nervous Disorders	Y N
HIV/AIDS	Y N	Bone Disorders/Bone Loss	Y N
Tonsils/Adenoids Removed	Y N	Seizures/Epilepsy	Y N
Handicaps/Disabilities	Y N	Neurological Disease	Y N
Arthritis / Joint problems	Y N	Asthma	Y N
Large Tonsils	Y N	Respiratory problems/Emphysema	Y N
Sinus trouble	Y N	Persistent swollen neck glands	Y N
Bed wetting	Y N	Sexually transmitted disease	Y N
Substance abuse problem	Y N	Low blood pressure	Y N
Bone fractures/trauma to face/jaw	Y N	Persistent cough	Y N
Prosthetic joints	Y N	FEMALES: Pregnant	Y N
Chronic fatigue	Y N	Take Bisphosphonates (Fosamax, Boniva)	Y N
Explain any “Yes”			

Patient Motivation for Orthodontic Treatment	
How would you change your teeth	
How would you change your facial appearance	
Where would you like to reduce the pain or discomfort	

Patients Under 18			
Height:		School:	
Weight:		Grade:	
Has patient begun puberty			Y N
If girl, has menstruation begun			Y N
If boy, has voice changed or have facial hair			Y N
Has the patient grown in the past year or has their shoe size changed recently			Y N
Has either biological parent ever had orthodontic treatment?			Y N
	I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.		
	I understand that where appropriate, credit bureau reports may be obtained.		

Date _____ Signature _____