PATIENT INFORMATION – PLEASE PRINT

NAME: _____ Cell Phone _____

Full Name of Legal Guardian or Parent: _____

Email: _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____ Weight _____ Height _____

Employer (or) School _____ Work Phone _____

General Dentist _____ City _____ State _____

Patient's Physician _____ City _____ State _____

INSURANCE INFORMATION – Person Responsible for Account

NAME _____ Date of Birth _____
Home Address (if different from above) _____ City _____ State ____ Zip _____
Dental Insurance Company _____ Do you have orthodontic coverage? ___ Yes ___ No
Subscriber ID # _____ Group Policy # _____

Who referred you to our office? _____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N) ALL RESPONSES ARE KEPT CONFIDENTIAL

1. Are you now or have you been in the last 5 years under the care of a physician. ……. Y N
   If so, for what? _____
2. Have you ever had any serious illness? ……... Y N
   If yes, explain _____
3. Are you taking any medications (vitamins, medicines, drugs) at the present time? ……. Y N
   Which ones? _____
4. Is it possible that you are pregnant at the present time? …… Y N
5. Do you take birth control pills? …… Y N
6. Do you smoke/chew tobacco? …… Y N
7. Have you ever had or been treated for: (circle appropriate ones) heart trouble, rheumatic fever, abnormal blood pressure, thyroid disorders, stomach disorders, hay fever, asthma, allergies, sinusitis, diabetes, epilepsy, gall bladder, tuberculosis, kidney or liver disease, joint problems, arthritis, anemia, hysterectomy, blood disorder, cancer, eye trouble? ……... Y N
8. Have you ever had or been treated for: (circle appropriate ones) hepatitis, AIDS, ARC? ……... Y N
9. Are you HIV positive? ……... Y N
10. Do you have any of the following: circle appropriate ones) fainting spells, shortness of breath, abnormally long bleeding when cut, swelling or bruising easily, abnormal healing time, easily acquired infections? ……..… Y N
11. Have you ever had local anesthetic (localized numbing)? …… Y N
    How did it affect you? _____
12. Have you ever had any adverse affects or allergic reaction from any anesthetic, antibiotic or other drug/medication?.. Y N
    Which drug/medication/anesthetic/antibiotic? _____
13. Have you had any radiation therapy for treatment of tumors, cancer, etc.? …… Y N
14. Do you have or have you ever had a heart murmur? …… Y N
    If so, please describe type of heart murmur _____
    During dental work, do you require antibiotic premedication for a heart murmur? ……..… Y N
15. Have you ever had a clicking, popping, or snapping in your jaw joint (ear area? …… Y N
    Which side (R or L)? _____ How long have you had it? _____
16. Do you have any pain or discomfort in your jaw joint area? …….. Y N
    Which side (R or L)? _____ When? AM _____ PM _____ Constantly _____
17. Has your jaw ever locked open or closed? ……..... Y N
18. Do you have any limited movement of your jaw? ……..…….. Y N
    When does the locking or limited movement occur? _____
19. Do you get frequent headaches? …… Y N
20. Do you grind or clench your teeth? ……..… Y N
    When do you do this (daytime or nighttime)? _____
21. Any history of trauma or injury to your teeth or jaws? ……... Y N
22. When was your last check-up with your family dentist? _____
23. Have you had a recent panoramic x-ray of full mouth series of x-rays taken? ……... Y N

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND I CONSENT TO ORTHODONTIC TREATMENT.

_____ _____
Signature of Parent/Patient/Legal Guardian completing Health History Date