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, anemia kidney or liver disease, joint problems, arthritis, tuberculosis, 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? ……
15. Have you ever had a clicking, popping, or snapping in your jaw joint or 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 limited movement or locking 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