PATIENT INFORMATION AND HEALTH HISTORY

PATIENTS FIRST NAME ______________________ LAST ______________________

Date of Birth ______________ Age ________ Gender M F Are You on Facebook? Y N

Address ______________________ City ______________ State ______ Zip ______

Home Phone ______________ Alternate Phone ______________ email address ______________

Patient's Chief Concern: ______________ Are you interested in conventional braces? ______ Invisalign? ______

General Dentists Name ______________ Last Checkup ________ Who Referred you? ______________

Friends or family in Practice ______________ Previous Orthodontic Consultation? ______________

RESPONSIBLE PARTY A INFORMATION

RELATIONSHIP ________ FIRST NAME ______________ LAST ______________

Date of Birth ______________ Social Security Number ______________

Address ______________________ City ______________ State ______ Zip ______

Home Phone ______________ Alternate Phone ______________ email address ______________

Occupation ______________ Employer ______________ Work Phone ______________

RESPONSIBLE PARTY B INFORMATION

RELATIONSHIP ________ FIRST NAME ______________ LAST ______________

Date of Birth ______________ Social Security Number ______________

Address ______________________ City ______________ State ______ Zip ______

Home Phone ______________ Alternate Phone ______________ email address ______________

Occupation ______________ Employer ______________ Work Phone ______________

DENTAL INSURANCE________________ MAY WE CHECK THIS FOR YOU ________________

Are Subscriber and responsible party the same? Y N

SUBSCRIBER:________________ INSURANCE COMPANY________________ GROUP NUMBER ________________

SS Number ________________ Date of Birth ________________ Phone Number ________________

SUBSCRIBER 2:________________ INSURANCE COMPANY2________________ GROUP NUMBER2 ________________

SS Number2 ________________ Date of Birth2 ________________ Phone Number2 ________________

MEDICAL HISTORY

MEDICATIONS ________________

ALLERGIES ________________

MAJOR ILLNESS ________________

OPERATIONS ________________

ACCIDENTS ________________

- ☐ ABNORMAL BLEEDING/HEMOPHILIA
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA OR HAYFEVER
- ☐ BONE DISORDERS
- ☐ CONGENITAL HEART DEFECT
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ GASTROINTESTINAL DISORDER
- ☐ HEART PROBLEMS
- ☐ HEART MURMUR
- ☐ HEPATITIS/LIVER PROBLEMS
- ☐ HERPES
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV/AIDS
- ☐ KIDNEY PROBLEMS TEETH
- ☐ NERVOUS DISORDER
- ☐ PNEUMONIA
- ☐ RADIATION/CHEMOTHERAPY
- ☐ RHEUMATIC FEVER
- ☐ TUBERCULOSIS
- ☐ TUMOR OR CANCER
- ☐ OTHER

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DENTAL HISTORY

- ☐ APPREHENSIVE ABOUT DENTAL CARE
- ☐ PRESENTLY IN DENTAL PAIN
- ☐ UNFAVORABLE REACTION TO DENTISTRY
- ☐ MISSING OR EXTRA PERM TEETH
- ☐ INJURY TO FACE, JAW, TEETH MOUTH
- ☐ BLEEDING GUMS
- ☐ ORAL HABITS
- ☐ MOUTH BREATHING
- ☐ DISCOMFORT FROM TEETH OR GUMS
- ☐ PAIN, TENDERNESS, NOISE IN JAW
- ☐ GRIND OR CLENCH TEETH
- ☐ FREQUENT SORE THROATS
- ☐ SPEECH PROBLEMS/THERAPY
- ☐ SNORES DURING SLEEP
- ☐ FREQUENT HEADACHES
- ☐ NECK/SHOULDER PAIN
- ☐ BRUSH DAILY
- ☐ FLOSS DAILY
- ☐ FLUORIDE TREATMENTS
- ☐ FREQUENTLY CHEW GUM
- ☐ REQUIRES PREMEDICATION

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- ☐ PREGNANT
- ☐ MENSTRUATION STARTED

SIGNATURE________________ **DATE**________________