New Patient Health History

Patient Biological Information

First Name:						
	Middle In	nitial:		Last Name:		
Date of Birth:	Gender:	Male	/Female	Nickname:		
Address:	City:		State:	Zip:		
Home Phone:	2 nd /Cell l	Phone:	:	E-Mail Address:		
Please list the names of any	friends or family cur	rently	in the practi	ce:		
Whom may we thank for ref	erring you to our pra	ctice?				
	Fina	ncia	I Party I	nformation		
First Name:	Middle I	nitial:		Last Name:		
Address:	City:		State:	Zip:		
Home Phone:	2 nd /Cell l	Phone	:	E-Mail Address:		
Social Security #:	Employer:			Occupation:		
Length of Employment:	Work Phone:			Relationship to Patient:		
			Y	ES NO		
	ance Company:		tal Histo			
If so, Please name the Insura	ance Company:		tal Histo			
If so, Please name the Insura Dentist Name: Has Patient had an orthodon	ance Company:	Den	tal Histo	ry		
If so, Please name the Insura Dentist Name: Has Patient had an orthodon If so, when?	tic consult or treatme	Den	tal Histo	ry ental exam:		
If so, Please name the Insura Dentist Name: Has Patient had an orthodon If so, when? What is patient's main ortho Brush teeth daily?	tic consult or treatme	Den	tal Histo	ry ental exam: NO Snores during sleep?	YES	NO
Do you have insurance that of If so, Please name the Insurance That is patient Name: Has Patient had an orthodon If so, when? What is patient's main orthodon If so, when?	tic consult or treatme	Den	tal Histo Last Do YES	ry ental exam: NO	YES YES	NO NO
Dentist Name: Has Patient had an orthodon If so, when? What is patient's main ortho Brush teeth daily? Floss teeth daily? Fluoride treatment?	tic consult or treatme	Den ent?	tal Histo Last Do YES NO NO	ry ental exam: NO Snores during sleep?		
Dentist Name: Has Patient had an orthodon If so, when? What is patient's main ortho Brush teeth daily? Floss teeth daily?	tic consult or treatme	Den ent? YES YES	tal Histo Last Do YES NO NO	ental exam: NO Snores during sleep? Sleep issues (daytime fatigue, apnea)	YES	NO
Dentist Name: Has Patient had an orthodon If so, when? What is patient's main ortho Brush teeth daily? Floss teeth daily? Fluoride treatment? Discomfort from teeth or gums	tic consult or treatmed dontic concern?	Den ent? YES YES YES YES	Last Do YES NO NO NO	ental exam: NO Snores during sleep? Sleep issues (daytime fatigue, apnea) Injury to face, jaw, teeth, or mouth?	YES YES	NO NO
Dentist Name: Has Patient had an orthodon If so, when? What is patient's main ortho Brush teeth daily? Floss teeth daily? Fluoride treatment?	tic consult or treatmed dontic concern?	Den YES YES YES YES YES YES	Last Do YES NO NO NO NO NO NO NO	Pry Ental exam: NO Snores during sleep? Sleep issues (daytime fatigue, apnea) Injury to face, jaw, teeth, or mouth? TMJ/TMD issues?	YES YES YES	NO NO NO
Dentist Name: Has Patient had an orthodon If so, when? What is patient's main ortho Brush teeth daily? Floss teeth daily? Fluoride treatment? Discomfort from teeth or gums Apprehensive about dental care' Any missing or extra permanent	tic consult or treatment dontic concern?	Pent? YES YES YES YES YES YES	Last Do YES NO NO NO NO NO NO NO NO NO	Snores during sleep? Sleep issues (daytime fatigue, apnea) Injury to face, jaw, teeth, or mouth? TMJ/TMD issues? Pain, tenderness, or noise in either jaw?	YES YES YES YES	NO NO NO
Dentist Name: Has Patient had an orthodon If so, when? What is patient's main ortho Brush teeth daily? Floss teeth daily? Fluoride treatment? Discomfort from teeth or gums Apprehensive about dental care' Any missing or extra permanent Oral Habits (thumb/finger habit.)	tic consult or treatment dontic concern?	Pent? YES YES YES YES YES YES	Last Do YES NO	Snores during sleep? Sleep issues (daytime fatigue, apnea) Injury to face, jaw, teeth, or mouth? TMJ/TMD issues? Pain, tenderness, or noise in either jaw? Grind or clench teeth?	YES YES YES YES YES	NO NO NO NO
Dentist Name: Has Patient had an orthodon If so, when? What is patient's main ortho Brush teeth daily? Floss teeth daily? Fluoride treatment? Discomfort from teeth or gums Apprehensive about dental care	tic consult or treatment dontic concern?	Den YES YES YES YES YES YES YES	VES NO	Snores during sleep? Sleep issues (daytime fatigue, apnea) Injury to face, jaw, teeth, or mouth? TMJ/TMD issues? Pain, tenderness, or noise in either jaw? Grind or clench teeth? Neck/shoulder pain?	YES YES YES YES YES YES	NO NO NO NO NO

Medical History

Tuberculosis/Lung Disease YES NO Family History of Cancer YES Pneumonia YES NO Received Radiation Treatment YES Liver Disease YES NO Growth Problems YES Kidney Disease YES NO Endocrine Problems YES Kidney Disease YES NO Endocrine Problems YES Heart Attack/Stroke YES NO Hormone Therapy YES Heart Disease YES NO Hormone Therapy YES Heart Disease YES NO Latex/Metal Allergy YES Congenital Heart Defect YES NO Nervous Disorder YES Heart Murmur YES NO Bone Disorders/Bone Loss YES Hemphilia YES NO Bone Disorders/Bone Loss YES Hemphilia YES NO Taken Bisphosphonate Medications YES Hypertension/High Blood Pressure YES NO Diabetes YES NO Diabetes YES NO Diabetes YES NO Diabetes YES NO Asthma YES NO Arthritis YES NO Arthritis YES NO Arthritis YES NO Arthritis YES NO Treated for Emotional problems YES NO If any of the above medical questions were answered "Yes" Please explain: ### Patients Under 18 ### Height: Weight: School: Grac Father/Guardian 1 Name: ### Mother/Guardian 2 Name: ### Patient is a girl, has menstruation begun? YES NO If patient is a girl, has menstruation begun? YES NO If patient is a boy, has their voice changed and/or shaving YES NO If patient is a boy, has their voice changed and/or shaving YES NO Has patient grown in the past year or has their shoe size changed recently? YES NO Has patient grown in the past year or has their shoe size changed recently? YES NO Has patient grown in the past year or has their shoe size changed recently? YES NO Has patient grown in the past year or has their shoe size changed recently? YES NO Has patient grown in the past year or has their shoe size changed recently? YES NO Has patient grown in the past year or has their shoe size changed recently? YES NO Has patient proven in the past year or has their shoe size changed recently?	Patient Health:		Patient	ician Name: Date of last Physical:		Physician Na		
List any drug allergies or sensitivities that patient may have: Rheumatic Fever			tate: Zip:	State:		City:	ess:	Address:
List any drug allergies or sensitivities that patient may have: Rheumatic Fever YES NO Cancer YES Tuberculosis/Lung Disease YES NO Family History of Cancer YES Pneumonia YES NO Received Radiation Treatment YES Liver Disease YES NO Growth Problems YES Kidney Disease YES NO Growth Problems YES Kidney Disease YES NO Endocrine Problems YES Kidney Disease YES NO Hormone Therapy YES Heart Attack/Stroke YES NO Hormone Therapy YES Congenital Heart Defect YES NO Latex/Metal Allergy YES Congenital Heart Defect YES NO Nervous Disorder YES Heart Murmur YES NO Bone Disorders/Bone Loss YES Hemophilia YES NO Taken Bisphosphonate Medications YES Hemophilia YES NO Taken Bisphosphonate Medications YES Hypertension/High Blood Pressure YES NO Diabetes Prolonged Bleeding/Transfusion YES NO Seizures/Epilepsy YES Anemia YES NO Asthma YES NO Asthma YES NO Asthma YES NO Arthritis YES Tonsils/Adenoids Removed YES NO Treated for Emotional problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional Problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional Problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional Problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional Problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional Problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional Problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional Problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional Problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional Problems YES Tonsils/Adenoids Removed YES NO Treated for Emotional Problems YES NO Treated for Emotional Problems				nt.	y the petier	r takan bi	any madications currently being t	List any mad
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	YES NO			•	_			
Has either biological parent ever had orthodontic treatment? YES NO				.c amade.				
Please list the name and birthdate of any siblings:			120 110					
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Date_____