New Patient Health History

Patient Biological Information

First Name: Middle Initial: Last Name:

Date of Birth: Gender: Male/Female Nickname:

Address: City: State: Zip:

Home Phone: 2nd/Cell Phone: E-Mail Address:

Please list the names of any friends or family currently in the practice:

Whom may we thank for referring you to our practice?

Financial Party Information

First Name: Middle Initial: Last Name:

Address: City: State: Zip:

Home Phone: 2nd/Cell Phone: E-Mail Address:

Social Security #: Employer: Occupation:

Length of Employment: Work Phone: Relationship to Patient:

Do you have insurance that covers orthodontics? YES NO
If so, Please name the Insurance Company:

Dental History

Dentist Name: Last Dental exam:

Has Patient had an orthodontic consult or treatment? YES NO
If so, when?

What is patient's main orthodontic concern?

Brush teeth daily?	YES	NO	Snores during sleep?	YES	NO
Floss teeth daily?	YES	NO	Sleep issues (daytime fatigue, apnea)	YES	NO
Fluoride treatment?	YES	NO	Injury to face, jaw, teeth, or mouth?	YES	NO
Discomfort from teeth or gums?	YES	NO	TMJ/TMD issues?	YES	NO
Apprehensive about dental care?	YES	NO	Pain, tenderness, or noise in either jaw?	YES	NO
Any missing or extra permanent teeth?	YES	NO	Grind or clench teeth?	YES	NO
Oral Habits (thumb/finger habit, lip/nail biting)	YES	NO	Neck/shoulder pain?	YES	NO
Mouth breather?	YES	NO	Frequent headaches?	YES	NO
Speech problems?	YES	NO	Frequently chews gum?	YES	NO

If any of the above dental questions were answered "Yes" please explain:

Medical History

Physician Name:	Date of last Physical:	Patient Health:

Address:	City:	State:	Zip:

List any medications currently being taken by the patient:

List any drug allergies or sensitivities that patient may have:

Rheumatic Fever	YES NO	Cancer	YES NO
Tuberculosis/Lung Disease	YES NO	Family History of Cancer	YES NO
Pneumonia	YES NO	Received Radiation Treatment	YES NO
Liver Disease	YES NO	Growth Problems	YES NO
Kidney Disease	YES NO	Endocrine Problems	YES NO
Heart Attack/Stroke	YES NO	Hormone Therapy	YES NO
Heart Disease	YES NO	Latex/Metal Allergy	YES NO
Congenital Heart Defect	YES NO	Nervous Disorder	YES NO
Heart Murmur	YES NO	Bone Disorders/Bone Loss	YES NO
Hemophilia	YES NO	Taken Bisphosphonate Medications	YES NO
Hypertension/High Blood Pressure	YES NO	Diabetes	YES NO
Prolonged Bleeding/Transfusion	YES NO	Seizures/Epilepsy	YES NO
Anemia	YES NO	Handicaps/Disabilities	YES NO
HIV/AIDS	YES NO	Asthma	YES NO
Hepatitis	YES NO	Arthritis	YES NO
Tonsils/Adenoids Removed	YES NO	Treated for Emotional problems	YES NO
Ever Been Hospitalized	YES NO		

If any of the above medical questions were answered “Yes” Please explain:

Patients Under 18

Height:	Weight:	School:	Grade:

Father/Guardian 1 Name: Mother/Guardian 2 Name:

___

Has patient begun puberty?	YES NO
If patient is a girl, has menstruation begun?	YES NO
If so, have cycles been regular for 1 year?	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
Is patient interested in orthodontic treatment? Positive attitude?	YES NO
Has either biological parent ever had orthodontic treatment?	YES NO

Please list the name and birthdate of any siblings:

___

Signature___________________________________ Date________________