Patient Information and Health History Form (part 1)

Patient Information

First Name ____ Nick Name ____ Last Name ____

Date of Birth ____ Gender ____

Are you on Facebook? ☐ Yes ☐ No

Address ____ City ____

Address Line 2 ____ State ____ Zip Code ____

☐ Cell Phone ____ ☐ Home Phone ____

Check Primary Phone

E-mail address:____

Person bringing Patient to their appointment: ____

Patient's chief concern: ____

If invisalign? Are you interested in conventional braces? ____

Who referred you? ____

General Dentist Name: ____ Last checkup Date____

Dentist address and phone number: ____

Previous orthodontic consult? ☐ Yes ☐ No

Previous Orthodontist: ____

Responsible Party A Information

Relationship ____ First Name ____ Last Name ____ DOB ____

Address ____ State ____

Address Line 2 ____ City ____ Zip Code ____

☐ Cell Phone____ ☐ Home Phone ____

E-mail address ____

SSN ____ Occupation ____ Employer ____

Responsible Party B Information

Relationship ____ First Name ____ Last Name ____ DOB ____

Address ____ State ____

Address Line 2 ____ City ____ Zip Code ____

☐ Cell Phone ____ ☐ Home Phone ____

E-mail address ____

SSN Occupation Employer

Patient Information and Health History Form (part 2)

____ ____

First Name Last Name

Dental Insurance available for orthodontics? _______________________ May we check this for you _____________

Are insurance subscriber and responsible party the same? ____________________

Subscriber (if different than RP) Insurance Company Group Number

SSN Date of Birth Phone Number (Insurance)

Subscriber 2 (if different than RP) Insurance Company 2 Group Number 2

SSN 2 Date of Birth 2 Phone Number 2 (Insurance)

Medical History

Medications: ____

Allergies: ____

Major Illness: ____

Any Surgeries: ____

Accidents: ____

Abnormal Bleeding/ Hemophilia	_____	Gastrointestinal Disorders	_____	Nervous Disorders	_____
Anemia	_____	Heart Problems	_____	Pneumonia	_____
Arthritis	_____	Heart Murmur	_____	Radiation/Chemotherapy	_____
Asthma or Hayfever	_____	Hepatitis/Liver Problem	_____	Rheumatic Fever	_____
Bone Disorders	_____	Herpes	_____	Tuberculosis	_____
Congenital Heart Defect	_____	High Blood Pressure	_____	Tumor or Cancer	_____
Diabetes	_____	HIV / Aids	_____		
Epilepsy	_____	Kidney Problems	_____		

Other Conditions:____

Dental History

Apprehensive about dental care	_____	Discomfort from teeth or gums	_____	Brush daily	_____
Presently in dental pain	_____	Pain, tenderness or noise in either jaw	_____	Floss daily	_____
Unfavorable reaction to dentistry	_____	Grind or clench teeth	_____	Fluoride treatments	_____
Missing or extra permanent teeth	_____	Frequent sore throats	_____	Frequently chew gum	_____
Injury to face, jaw, teeth, or mouth	_____	Speech problems / therapy	_____	Requires premedication	_____
Bleeding gums	_____	Snores during sleep	_____		
Oral habits	_____	Frequent headaches	_____	PREGNANT	_____
Mouth breathing	_____	Neck /shoulder pain	_____	Menstruation Started	_____

Signature ____ Date ____________________