New Patient Health History

Patient Biographical Information			
First Name:	Middle Initial:	Last Name:	Nickname:
Birth date	Gender:		
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Email:	
Please list the names of any friends or family currently in the practice			
List any sports, hobbies, or musical instruments played:			
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:	Email:	
Date of Birth:	Employer	Occupation:	
Length of Employment	Work Phone	Relationship to Patient	
Do you have insurance that covers orthodontics?	If so, please name the Insurance Company:		

Dental History			
Dentist Name:			
Check-up Frequency:	Last Dental Visit:		
Has the patient had an orthodontic consult or treatment	If so, when		
What is the patient's main orthodontic concern?			
Speech problems/therapy?	Brush teeth daily?		
Grind or clench teeth?	Floss teeth daily?		
Oral habits (thumb/finger habit, lip/nail biting)?	Fluoride treatments?		
Injury to face, jaw, teeth, or mouth?	Mouth breathing?		
Discomfort from teeth or gums?	Snores during sleep?		
Pain, tenderness, or noise in either jaw?	Requires premedication?		
Frequent headaches?	Any missing or extra permanent teeth?		
Neck/shoulder pain?	Apprehensive about dental care?		

Frequent sore throats?	Frequently chews gum?
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 the patient may have:			

Rheumatic Fever	Cancer
Tuberculosis/Lung Disease	Family History of Cancer
Pneumonia	Received Radiation Treatment
Liver Disease	Growth Problems
Kidney Disease	Endocrine Problems
Heart Attack/Stroke	Hormone Therapy
Heart Disease	Latex/Metal Allergy
Congenital Heart Defect	Nervous Disorders
Heart Murmur	Bone Disorders/Bone Loss
Hemophilia	Diabetes
Hypertension/High Blood Pressure	Seizures/Epilepsy
Prolonged Bleeding/Transfusion	Handicaps/Disabilities
Anemia	Asthma
HIV/AIDS	Arthritis
Hepatitis	Treated for Emotional Problems
Tonsils/Adenoids Removed	Ever Been Hospitalized
If any of the above medical questions were answered "Yes," please explain:	

Patients Under 18			
Please list the name and birth date of any siblings:			
Height:	Weight:	School	Grade:
Father/Guardian 1 Name		Mother/Guardian 2 Name	
Has patient begun puberty?			
If patient is a girl, has menstruation begun?			
If patient is a boy, has their voice changed or have facial hair?			
Has the patient grown in the past year or has their shoe size changed recently?			
Patient's interest in treatment?			
Has either biological parent ever had orthodontic treatment?			

Signature: _____Date:_____