DENTALPROS ORTHOPROS

A Smile Says So Much!

Health History

Patient Name ______________________________ Preferred Name/Nickname ______________________

Address ____

City ______________ State____________ Zip ____________ Home Phone ______________________

Birth Date ______/______/______ Age_______ Sex: ☐ M ☐F Height __________ Weight ____________

Grade ____________ School ____

Medical Health Information

Is patient adopted? ☐Yes ☐No If yes, at what age? __________

Name of physician____

Address ____ Phone ________________________

Does the patient have or has he/she had any of the following diseases or conditions (Check those that apply)

Yes	No		Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Fainting Spells, Seizures	☐	☐	AIDS, HIV +
☐	☐	Stroke	☐	☐	Rheumatic Heart Disease	☐	☐	Herpes, Fever Blisters
☐	☐	Asthma	☐	☐	Allergies (medicine or other)	☐	☐	Joint Replacement / Implant
☐	☐	Hepatitis or Liver disease	☐	☐	Latex or Nickel Sensitivity/ Allergy	☐	☐	Excessive Bleeding / Bruising
☐	☐	Tonsillitis	☐	☐	High or Low Blood Pressure	☐	☐	Drug or Alcohol Dependency
☐	☐	Heart Defect, Heart Murmur, Heart Disease				☐	☐	Tonsils/ Adenoids Removed

Do you/your child have any drug allergies? ☐ Yes ☐ No

List:____

Do you/your child take any blood thinners? ____

Do you/your child, now or has he/she ever taken any medications for their bones, Ex: bisphosphonates, Fosamax, Boniva, Actonel, or Zometa? ____ If so, which drug? ____

If female, has she begun menstruating? ☐ Yes ☐ No

Do you/your child have any disease, condition, or problem not listed that you think we should know about?

Please Explain: ____

Are you/your child taking any medication at this time? ☐ Yes ☐ No

List:____

Dental Health Information

Are you/your child experiencing any dental Problems? ☐ Yes ☐ No Date Of Last Dental visit: _____/_____/_______

How often does the patient brush and floss each day? Brushes __________ times per day Flosses__________ times per day

Most recent dentist ______________ Address ______________________________ Phone ____________

Does the patient have or has he/she had any of the following diseases or problems?

Yes	No		Yes	No		Yes	No	
☐	☐	Tongue Thrust	☐	☐	Jaw Pain (Joint, Ear, Side of Face)	☐	☐	Extra Permanent Teeth
☐	☐	Sore or Bleeding Gums	☐	☐	Tooth Sensitivity to Heat, Cold or Sweets	☐	☐	Fear of Dental Work
☐	☐	Permanent Tooth Extraction	☐	☐	Previous Orthodontic Treatment	☐	☐	Clenching or Grinding
☐	☐	Difficulty Chewing	☐	☐	Head/ Neck, Jaw or Tooth Injury	☐	☐	Finger or Lip Sucking Habit
☐	☐	Missing Permanent Teeth	☐	☐	Clicking or Popping of the Jaw Joints	☐	☐	Chronic Mouth Breather

Self/Parents or Guardians

Patient Lives With: ☐ Self ☐ Both Parents Together ☐ Both Parents Separately ☐ Mother ☐ Father ☐ Other

Father/Guardian ___________________ Employer _____________________________Cell Phone _________________________

Mother/ Guardian __________________ Employer _____________________________Cell Phone _________________________

E-Mail Address ____

Orthodontic Treatment Information

What is the reason you are seeking an orthodontic evaluation? ____

Has an orthodontist been consulted previously? ☐Yes ☐No Reason: ____

Patient's attitude toward orthodontic treatment ☐ Very Motivated ☐ Will Cooperate (If needed) ☐ Not Motivated

Dental Insurance Information

Primary Insurance Company Name ___________________________ Employer Name _________________________________

Phone # ____________________________________ ID# ____

Address ____

Group/Plan Number ____

Primary Policy Holder Name ____ Social Security Number _____/_____/_____

Date of Birth ________/_________/__________

Personal Information

Does the patient have any siblings? ☐ Yes ☐ No If yes, what are their ages? _____________________________________

Please list other family members seen in our office and their relationship to this patient:

____

Please list any special interests of the patient (sports hobbies, etc.)

____

____

How did you hear about our office? ____

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in the patient's medical status.

Signature of Patient/Guardian ____ Date _______________________

Doctor's Signature ____Date __________________________