

**PATIENT INFORMATION AND HEALTH HISTORY**

**C**

*Thank you for completing this information before your first visit.  
It is a confidential part of our patient records.*



Exam date \_\_\_\_\_ Exam time \_\_\_\_\_

**Patient Information**

Patient's last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ Phone \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F

Other family members under treatment at this office? \_\_\_\_\_

What is the nature of your dental concern? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**Responsible Party Information**

Last name \_\_\_\_\_ First name \_\_\_\_\_ Marital status \_\_\_\_\_

Residence  Same as patient or \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing address  Same as patient or \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How long at this address? \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Previous address (if less than 3 years) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social security # \_\_\_\_\_ Date of birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. of years employed \_\_\_\_\_

Spouse's last name \_\_\_\_\_ First name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Social security # \_\_\_\_\_ Date of birth \_\_\_\_\_ Work phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. of years employed \_\_\_\_\_

**Family Information (Child Patient)**

We request the following information so we are able to communicate effectively with the people involved in your treatment.

With whom does the patient live? \_\_\_\_\_

Are the parents married?  yes  no      Separated?  yes  no      Divorced?  yes  no      Remarried?  yes  no

**Parent Information**

**Patient's Father**

Last name \_\_\_\_\_ First name \_\_\_\_\_

Residence  Same as patient or \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

**Patient's Mother**

Last name \_\_\_\_\_ First name \_\_\_\_\_

Residence  Same as patient or \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

**Other persons we should know about (i.e. stepparents)**

Last name \_\_\_\_\_ First name \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Residence  Same as patient or \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## MINOR PATIENT GROWTH INFORMATION

Height of: Patient \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_

Have any members of the family had orthodontic treatment? If yes, who and where

### Dental History

Patient's dentist \_\_\_\_\_

Date of last cleaning \_\_\_\_\_

Has all dental work/fillings been completed  yes  no

Check if the patient has or has had:

extra teeth  gum disease or infection

missing teeth  teeth sensitive to hot, cold, or sweets

Check all that apply to patient:	Yes	If yes, please explain
Prior orthodontic evaluation		Date: _____
Prior orthodontic treatment		Date: _____
History of thumb or finger sucking		
Is patient sensitive about their habit?		
Breathes with mouth open		
Extracted teeth		
Had a severe injury to the head, face, or teeth		Date: _____
Treatment by periodontist, endodontist, or oral surgeon		
Negative or resistant feelings about braces		
Dissatisfied with the appearance of their teeth		

### Temporomandibular Joint

Check all that apply to patient:	Yes	If yes, please explain
Treatment for a jaw joint problem		
History of clenching or teeth grinding		
Jaw joint (TMJ) makes noise or hurts when moving		
Pain in or around the teeth, ears, temples, or cheeks		
Bite feels uncomfortable or unusual		
Frequent headaches		

### Transfer Orthodontic Patient

Patient's orthodontist \_\_\_\_\_

Address \_\_\_\_\_

Date of last adjustment \_\_\_\_\_

### Has the patient:

Had unusual growth rates  yes  no

Inherited family facial or dental characteristics  yes  no

Reached puberty  yes  no

(generally signalled by voice changing in boys and menstrual cycle in girls)

### Medical History

Patient's physician \_\_\_\_\_

Check all that apply to patient:	Yes	If yes, please explain
Current or past medical conditions		List: _____
Taking any medication(s)		List: _____
Allergies		List: _____
Unfavorable reaction to medications		
Any surgery or hospitalizations		
Emotionally, mentally or physically challenged		

### Please check any of the following which the patient has or has had:

- |  |   |
|--|---|
| <input type="checkbox"/> Adenoids removed at age _____ | <input type="checkbox"/> Heart disease                  |
| <input type="checkbox"/> Tonsils removed at age _____  | <input type="checkbox"/> Heart murmur                   |
| <input type="checkbox"/> AIDS or HIV positive          | <input type="checkbox"/> Hepatitis                      |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> High blood pressure            |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Hyperactivity                  |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Kidney problems                |
| <input type="checkbox"/> Bleeding problems             | <input type="checkbox"/> Latex allergy                  |
| <input type="checkbox"/> Bone disorders                | <input type="checkbox"/> Liver problems                 |
| <input type="checkbox"/> Cleft lip                     | <input type="checkbox"/> Malignancies, tumors, cancers  |
| <input type="checkbox"/> Cleft palate                  | <input type="checkbox"/> Prosthetic joint (replacement) |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Radiation therapy              |
| <input type="checkbox"/> Dizziness                     | <input type="checkbox"/> Rheumatic/Scarlet fever        |
| <input type="checkbox"/> Epilepsy or convulsions       | <input type="checkbox"/> Speech problems                |
| <input type="checkbox"/> Fainting                      | <input type="checkbox"/> Thyroid or hormonal imbalance  |
| <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> Hearing problems              | <input type="checkbox"/> Wears contact lenses           |

### Are there any other dental or medical concerns we should know about?

\_\_\_\_\_

### Signatures

This information is complete and accurate. If any information changes, I will notify Dr. Smith's office immediately. I authorize the release of my records (child's records) to my insurance company, physician, or dentist as deemed necessary in the professional judgment of my dentist.

\_\_\_\_\_  
Patient signature/guardian signature of minor patient date

I understand that where appropriate credit reports may be obtained.

\_\_\_\_\_  
Patients signature/guardian signature of minor patient date