



## Patient Registration Health History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Nickname: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ School: \_\_\_\_\_  
 Hobbies: \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_  
 Name of family members we have treated and relationship: \_\_\_\_\_  
 \_\_\_\_\_

Parents Divorced:  YES  NO

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

(Please complete other responsible party information on reverse side of this form)

## Dental History

General Dentist: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Reason for Orthodontic Consultation: \_\_\_\_\_

Does the patient have to take antibiotics for dental treatment?  YES  NO

Explain: \_\_\_\_\_

What is your main concern regarding orthodontics? \_\_\_\_\_  
 \_\_\_\_\_

Do you feel patient will cooperate fully in orthodontic treatment? \_\_\_\_\_

Are you presently in dental pain?  YES  NO

Have you ever experienced unfavorable reaction to dentistry?  YES  NO

Have you ever lost or chipped any teeth?  YES  NO

Have there been any injuries to your face, mouth, or teeth?  YES  NO Where? \_\_\_\_\_

Is any part of your mouth sensitive to temperature?  YES  NO Where? \_\_\_\_\_

Is any part of your mouth sensitive to pressure?  YES  NO Where? \_\_\_\_\_

Do your gums bleed when you brush?  YES  NO

Do you have any type of thumb or tongue habit?  YES  NO Age when stopped: \_\_\_\_\_

Are you a mouth breather?  YES  NO

Have you ever seen an Orthodontist?  YES  NO If yes, who and when? \_\_\_\_\_

Has anyone in your family received orthodontic treatment?  YES  NO

Do your teeth or jaws ever feel uncomfortable when you awake in the morning?  YES  NO

Are you aware of your jaw clicking or popping?  YES  NO

Have you ever been told that you grind your teeth?  YES  NO

Do you have "tension" headaches?  YES  NO

Have you ever experienced chronic ringing in the ears?  YES  NO

Do you have sleep apnea or do you snore?  YES  NO

Have you had your tonsils or adenoids removed?  YES  NO

If the patient is under age 16, height of parents: Mother: \_\_\_\_\_ Father: \_\_\_\_\_

# Medical History

Physician: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Does the patient have to take antibiotics for dental treatment?  YES  NO

### Please check Yes or No (If Yes, please fill in details)

Are you taking any medications?  YES  NO List medications: \_\_\_\_\_

Are you allergic to any medication?  YES  NO \_\_\_\_\_

Do you have a history of a major illness?  YES  NO \_\_\_\_\_

Have you had any operations?  YES  NO \_\_\_\_\_

Have you ever been involved in a serious injury?  YES  NO \_\_\_\_\_

Have you seen a physician in the last 12 months?  YES  NO Why?: \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have:

Abdominal Bleeding

Cold Sores/Fever Blisters

Hepatitis/Liver Problems

Pneumonia

ADD/ADHD

Congenital Heart Disease

Herpes

Prolonged Bleeding

Anemia

Diabetes

HIV/Aids

Radiation/Chemotherapy

Arthritis

Dizziness

Kidney Problems

Rheumatic Fever

Asthma

Epilepsy

Nervous Disorders

Thyroid Problems

Autism

Gastro Disorder

Osteoporosis

Tuberculosis

Back/Neck Pain

Heart Murmur

Heart Problems

Tumor or Cancer

Bi-Polar

High Blood Pressure

Are there any medical conditions we have not discussed that you feel we should be aware of?

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# Responsible Party Information

Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Social Security No. \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## (Spouse, Additional Responsible Party, or Other)

Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Social Security No. \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Who will be responsible for payments? \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Social Security No. \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Group No. \_\_\_\_\_ Subscriber ID No. \_\_\_\_\_  
Insurance Phone Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Do you have dual coverage?  YES  NO If Yes: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Social Security No. \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Group No. \_\_\_\_\_ Subscriber ID No. \_\_\_\_\_  
Insurance Phone Number: \_\_\_\_\_ Employer: \_\_\_\_\_

## EMERGENCY INFORMATION

Name of nearest relative not living with you: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Are you aware that some appointments will be during school/work hours?**  YES  NO

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth. In the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body party and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I also give permission for this office to release or submit information to the insurance company where necessary. I understand that, where appropriate, credit bureau reports may be obtained.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_