



**ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY**

**Patient Name:** \_\_\_\_\_ **Nickname:** \_\_\_\_\_  
**Today's Date:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** \_\_\_\_\_  
**Home Address:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_  
 \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_  
**Hobbies/Sports:** \_\_\_\_\_

**FAMILY**

**Father's Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Relationship to patient:** Biological Step-father Adoptive **Employer:** \_\_\_\_\_  
**Mother's Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Relationship to patient:** Biological Step-mother Adoptive **Employer:** \_\_\_\_\_  
**Parents' Marital Status:** Married Divorced Separated Widowed Not married  
**Patient Living with:** Mother Father Other: \_\_\_\_\_  
**Siblings (name and age):** \_\_\_\_\_  
 \_\_\_\_\_

**PERSON(S) RESPONSIBLE FOR FINANCIAL MATTERS**

**Name(s):** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
 \_\_\_\_\_  
**Home phone:** \_\_\_\_\_  
**Business phone:** \_\_\_\_\_  
**Cell phone:** \_\_\_\_\_  
**Place of employment:** \_\_\_\_\_  
**SS #:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_

Is the patient covered by insurance for orthodontic treatment? \_\_\_\_\_

	<b>PATIENT'S DENTIST</b>	<b>PATIENT'S PHYSICIAN</b>	<b>REFERRED BY</b>
<b>Name:</b>	_____	_____	_____
<b>Address:</b>	_____	_____	_____
	_____	_____	_____
<b>Phone:</b>	_____	_____	_____

Has any other orthodontist been consulted regarding this patient? \_\_\_\_\_

Has the patient had previous orthodontic treatment (please explain)? \_\_\_\_\_

### MEDICAL HISTORY

Please describe any major illnesses or hospitalizations: \_\_\_\_\_

Is the patient taking any medications? \_\_\_\_\_

Has the patient been under the care of a physician during the past 3 years, other than for routine examination (please explain)? \_\_\_\_\_

Has the patient ever had (please circle):

Abnormal blood pressure	Diabetes	Heart valve condition
Abnormal bleeding	Dizziness	Hepatitis
ADD/ADHD	Eating disorder	HIV positive status
Anemia	Emotional problems	Kidney disease
Arthritis	Endocrine disorder	Oral ulcers
Asthma	Epilepsy and/or seizures	Rheumatic fever
Autism	Headaches/migraines	Sleep disturbances
Autoimmune disorder	Head or face injury	Speech difficulties
Blood/bone disorder	Hearing impairment	Surgery
Cancer	Heart disease	Thyroid condition
Cold sores	Heart murmur	Tuberculosis

Other (please describe): \_\_\_\_\_

Does the patient have any allergies? \_\_\_\_\_

Does the patient require premedication prior to dental treatment? \_\_\_\_\_

Has the patient reached puberty (menstruation, voice change)? Yes No How long ago? \_\_\_\_\_

### DENTAL HISTORY

Date of last dental visit: \_\_\_\_\_ Were the patient's teeth cleaned at that visit? Yes No

How often does the patient brush his/her teeth? \_\_\_\_\_

Is there a history of trauma to any teeth? Yes No

If so, please explain: \_\_\_\_\_

Has the patient ever sucked his/her thumb or fingers? Yes No

Is there a history of lip biting or lip sucking? Yes No

Is there a history of nail biting? Yes No

Is there a history of clenching or grinding the teeth? Yes No

Is there a history of pain or clicking/popping in or around the ear or jaw joint (TMJ)? Yes No

Is there a tongue thrust habit or other functional problem? Yes No

Are there frequent sore throats or a history of tonsillitis? Yes No

Is there a history of mouth breathing or snoring? Yes No

Does the patient experience difficulty or pain when chewing? Yes No

What is the patient's or parent's primary concern? What brings you to the office today? \_\_\_\_\_

What is expected from orthodontic treatment? \_\_\_\_\_

What is the patient's interest in orthodontic treatment?

Wants treatment      Only if necessary      Unwilling, but will cooperate      Uncooperative

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? \_\_\_\_\_

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

Signature of adult patient or parent/guardian

Date