New Patient Health History

Patient Biographical Information			
First Name:	Middle Initial:	Last Name:	Nickname:
Birth date:	Gender:	Social Security #:	
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Email:	
Please list the names of any friends or family currently in the practice:			
School:			
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:
Main Phone:	2nd/Cell Phone:	Email:	
Social Security #:	Employer:	Occupation:	
Length of Employment:	Work Phone:	Relationship to Patient:	
Spouse or other parent first name:	Middle Initial:	Last Name:	
Social Security:	Birthdate:	Relationship to patient:	
Employer:	Occupation:	Length of employment:	
Work Phone:			

Dental Insurance Information			
Primary Dental Insurance			
Policy Holder's Name:		Subscriber ID#:	
Insurance Company:		Group #:	
Address:		Phone #:	
City:		Employer:	
State:		Relationship to Patient:	
Zip:			
Dual Dental Coverage:			
Policy Holder's Name:		Subscriber ID#:	
Insurance Company:		Group #:	
Address:		Phone #:	

City:		Employer:	
State:		Relationship to Patient:	
Zip:			

Emergency Information			
Nearest relative not living with you:			
Complete Address:			
Phone:		Relationship to Patient:	

Dental History			
Dentist Name:			
Check-up Frequency:		Last Dental Visit:	
Height of mother?		Height of father?	
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?	
Injury to face, jaw, teeth, or mouth?		Fluoride treatments?	
Discomfort from teeth or gums?		Mouth breathing?	
Ever experienced any unfavorable reaction to dentistry?		Snores during sleep?	
Has the patient ever lost or chipped any teeth?		Requires premedication?	
Is any part of the patient's mouth sensitive to temperature?		Any missing or extra permanent teeth?	
Is any part of the patient's mouth sensitive to pressure?		Apprehensive about dental care?	
Pain, tenderness, or noise in either jaw?		Is the patient sensitive or self-conscious about his/her teeth?	
Oral habits (thumb/finger habit, lip/nail biting)?		Are you aware that some appointments will be during school/work hours?	
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:			
Tuberculosis/Lung Disease		Cancer	
Liver Disease		Received Radiation Treatment	
Heart Attack/Stroke		Growth Problems	

Heart Disease	Hormone Therapy
Congenital Heart Defect	Latex/Metal Allergy
Heart Murmur	Bone Disorders/Bone Loss
Hemophilia	Diabetes
Prolonged Bleeding/Transfusion	Seizures/Epilepsy
Anemia	Handicaps/Disabilities
HIV/AIDS	Asthma
Hepatitis	Treated for Emotional Problems
Herpes	Is the patient pregnant
Tonsils/Adenoids Removed	
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: _____