# New Patient Health History

| Patient Biographical Information | | | |
|---|---|---|---|
| First Name: | Middle Initial: | Last Name: | |
| Nickname: | Birthdate: | Gender: | |
| Address: | City: | State: | Zip: |
| Main Phone: | 2nd/Cell Phone: | Email: | |
| Social Security #: | | | |
| Please list the names of any friends or family currently in the practice: | | | |
| List any sports, hobbies, or musical instruments played: | | | |
| Whom may we thank for referring you to our practice? | | | |
| Preferred T-Shirt Size: | | | |

| Financial Party Information | | | |
|---|---|---|---|
| First Name: | Middle Initial: | Last Name: | |
| Birthdate: | Relationship to Patient: | Email: | |
| Address: | City: | State: | Zip: |
| Main Phone: | 2nd/Cell Phone: | Social Security #: | |
| Employer: | Occupation: | Length of Employment: | |
| Work Phone: | | | |
| Do you have insurance that covers orthodontics? Yes No | If so, please name the Insurance Company: | | |

| Dental History | | | |
|---|---|---|---|
| Dentist Name: | | | |
| Check-up Frequency: | | Last Dental Visit: | |
| Has the patient had an orthodontic consult or treatment? Yes No | | If so, when? | |
| What is the patient's main orthodontic concern? | | | |
| | | | |
| Speech problems/therapy? Yes No | | Grind or clench teeth? Yes No | |
| Injury to face, jaw, teeth or mouth? Yes No | | Discomfort from teeth or gums? Yes No | |
| Pain, tenderness or noise in either jaw? Yes No | | Frequent headaches? Yes No | |
| Oral Habits (thumb/finger sucking, lip/nail biting)? Yes No | | Neck/shoulder pain? Yes No | |
| Frequent sore throats? Yes No | | Brush teeth daily? Yes No | |
| Floss teeth daily? Yes No | | Fluoride treatments? Yes No | |
| Mouth Breathing? Yes No | | Snores during sleep? Yes No | |
| Requires premedication? Yes No | | Any missing or extra permanent teeth? Yes No | |
| Apprehensive about dental care? Yes No | | Frequently chew gum? Yes No | |
| 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: | | | | | | | |
| | | | | | | | |
| Rheumatic Fever | Yes No | | | Tuberculosis/Lung Disease | Yes No | | |
| Pneumonia | Yes No | | | Liver Disease | Yes No | | |
| Kidney Disease | Yes No | | | Heart Attack/Stroke | Yes No | | |
| Heart Disease | Yes No | | | Congenital Heart Defect | Yes No | | |
| Heart Murmur | Yes No | | | Hemophilia | Yes No | | |
| Hypertension/High Blood Pressure | Yes No | | | Prolonged Bleeding/Transfusion | Yes No | | |
| Anemia | Yes No | | | HIV/AIDS | Yes No | | |
| Hepatitis | Yes No | | | Tonsils/Adenoids Removed | Yes No | | |
| Cancer | Yes No | | | Family History of Cancer | Yes No | | |
| Received Radiation Treatment | Yes No | | | Growth Problems | Yes No | | |
| Endocrine Problems | Yes No | | | Hormone Therapy | Yes No | | |
| Latex/Metal Allergy | Yes No | | | Nervous Disorders | Yes No | | |
| Bone Disorders/Bone Loss | Yes No | | | Diabetes | Yes No | | |
| Seizures/Epilepsy | Yes No | | | Handicaps/Disabilities | Yes No | | |
| Asthma | Yes No | | | Arthritis | Yes No | | |
| Treated for Emotional Problems | Yes No | | | Ever Been Hospitalized | Yes No | | |
| 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? | | Yes No | |
| If patient is a girl, has menstruation begun? | | Yes No | |
| If patient is a boy, has their voice changed or have facial hair? | | Yes No | |
| Has the patient grown in the past year or has their shoe size changed recently? | | Yes No | |
| Patient’s interest in treatment? | | | |
| Has either biological parent ever had orthodontic treatment? | | Yes No | |

Signature: _____ Date: _____