

Please provide us with the following information:

Patient's Last Name: _____ 1st _____ Middle _____ Sex: M F Birth Date: _____ Age: _____

Patient's Address: _____ Home Phone: _____ Work Phone: _____
Number Street

City State Zip

School/Employer: _____ Grade/Dept: _____ Soc. Sec. No: _____

Father/Husband: _____ Home Phone: _____ Work Phone: _____

Address: _____ Years: _____ Soc. Sec. No: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ Birth Date: _____

Employer: _____ Dept: _____ OK to contact at office? Yes No

Does Father/Husband have insurance that covers orthodontic treatment? Yes No

Insurance Co: _____ Phone: _____ Address: _____

Mother/Wife: _____ Home Phone: _____ Work Phone: _____

Address: _____ Years: _____ Soc. Sec. No: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ Birth Date: _____

Employer: _____ Dept: _____ OK to contact at office? Yes No

Does Mother/Wife have insurance that covers orthodontic treatment? Yes No

Insurance Co: _____ Phone: _____ Address: _____

If divorced or separated, who is custodial parent? Mother Father

Names and ages of other children in your family: _____

Have we ever treated any of your relatives? Yes If YES, whom? _____

In case we can't reach you, who can we contact? _____
Person's Name Phone Number Relationship

Is there someone we can thank for referring you to our office? _____

Please understand that when appropriate, credit bureau reports may be obtained.

Signature of parent or responsible party filling out this page: _____
Signature Date

**Health History
 Questionnaire
 Instructions:**

1. Please answer every question requested on the following three pages by checking off yes or no.
2. If you answer YES, please check off any "specifics" of the problem and "Please Explain..." any specifics, medication dosage, etc.
3. Please sign and date the last page and bring this form with you to your appointment.

Dental History:

Name of Your Family Dentist: _____ Date of your last visit to the dentist: _____

Dental Specialists who have Treated you (Give Names, Treatments & Dates): _____

How many times per day do you **BRUSH** your teeth? 0 1 2 3+

How many times per day do you **FLOSS** your teeth? 0 1 2+

History Of: Specifics of Problems if YES:

Please Explain any YES answers

Tooth Injury? NO YES Chipped Broken Lost

Jaw Injury? NO YES At Age _____

Oral Disease? NO YES Ulcers Sores

Jaw Joint Pain? NO YES Right T.M.J. Constant Periodic
 Left T.M.J. Constant Periodic

When you: Chew Yawn Talk Open Wide

When you: Chew Yawn Talk Open Wide

Comments: _____

Jaw Joint Noises? NO YES Right T.M.J. Click Popping Grating At Age: _____
 Left T.M.J. Click Popping Grating

Jaw Locking? NO YES Right T.M.J. When Open When Closed Dates of Locking: _____
 Left T.M.J. When Open When Closed

Grinding Your Teeth? NO YES During The Day _____
 When Sleeping _____

Clinching Your Teeth? NO YES During The Day _____
 When Sleeping _____

Bleeding Gums? NO YES Usually Sometimes Rarely Presently under a Dentist's care for it? No Yes _____
 When: Brushing Flossing Eating

Oral Habits? NO YES Thumb Sucking Finger Sucking _____
 Tongue Twisting Nail Biting Lip Biting

Speech Problems? NO YES Lisper Speech Therapy At What Age? _____ For What Sounds? _____

Other Oral Problems? NO YES If YES, please explain: _____

Orthodontic Concerns? What are the orthodontic concerns of patient/parent? _____

What are the orthodontic concerns of your dentist? _____

Have you ever had:

Doctor: _____

Periodontal (gums) Treatment: NO YES What kind of treatment? _____

Orthodontic (braces) Treatment: NO YES What kind of treatment? _____

Endodontics (root canal) Treatment: NO YES What kind of treatment? _____

Oral Surgery (tooth removal) Treatment: NO YES What kind of treatment? _____

Prosthodontics (crown & bridge) Treatment: NO YES What kind of treatment? _____

I hereby certify that I have reviewed the above medical history and that it is accurate to my knowledge at this time. If there are any further changes in this information, I will inform this practice of these changes.

Signature of Person filling Out This Health History _____

Date this History was Completed _____

Signature of T.C. who reviewed this health history _____

Signature that the examination DOCTOR reviewed this history _____

Date of interview and DOCTOR review of this history _____

Date above T.C. reviewed this health history _____

Notes: _____

Medical History:

What is the name of your family physician? _____ Date of your last visit to this physician: _____
 Are there any Medical Specialists you see regularly? _____ Specialty: _____
 When was the last time you had a complete physical exam? Date _____ Examining doctor's name: _____
 What is your approximate height? _____ feet, _____ inches. What is your approximate weight? _____ pounds, Body Frame size: Small Medium Large

History Of:	Specifics of Problems if YES:	Please Explain... Also indicate any Medication (dosage)
Head/Neck Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES Headaches: <input type="checkbox"/> Migraine <input type="checkbox"/> Sinus <input type="checkbox"/> Eyes <input type="checkbox"/> Temples <input type="checkbox"/> Back of Head <input type="checkbox"/> Painful Scalp <input type="checkbox"/> Neck pain <input type="checkbox"/> Lumps in neck <input type="checkbox"/> Tired/Sore Neck Muscles	_____
Neural Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Epilepsy <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Other _____	_____
Eye Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Pain <input type="checkbox"/> Bloodshot <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Pressure on Eyeballs <input type="checkbox"/> Light Sensitivity <input type="checkbox"/> Watery <input type="checkbox"/> Drooping Eyelids <input type="checkbox"/> _____	_____
Ear Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Pain <input type="checkbox"/> Clogged <input type="checkbox"/> Hisses <input type="checkbox"/> Ringing <input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Loss of Hearing Volume <input type="checkbox"/> Loss of Balance	_____
Nose/Sinus Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Obstruction <input type="checkbox"/> Stiffness <input type="checkbox"/> Runny Nose	_____
Throat Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Sore Throat <input type="checkbox"/> Swallowing Difficulties <input type="checkbox"/> Lump in Throat <input type="checkbox"/> Laryngitis <input type="checkbox"/> Voice Fluctuations <input type="checkbox"/> Tongue Pain <input type="checkbox"/> Persistent Coughing/Clearing Throat	_____
Breathing Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Asthma <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Cough up Blood/Sputum <input type="checkbox"/> Snoring <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Mouth Breather	_____
Back, Shoulders, Extremities Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Aching Shoulders <input type="checkbox"/> or Stiffness <input type="checkbox"/> Lack of Mobility <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Back Pain <input type="checkbox"/> Numbness in Arms Cramps in Legs: <input type="checkbox"/> When Walking <input type="checkbox"/> At Night <input type="checkbox"/> Arms/Legs Weakness <input type="checkbox"/> Leg/Ankle Swelling <input type="checkbox"/> Gout	_____
Bone Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Break Easily <input type="checkbox"/> Pain <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Swelling	_____
Breast Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Pain <input type="checkbox"/> Lumps <input type="checkbox"/> Disease _____	_____
Heart Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Coronary Heart Disease <input type="checkbox"/> Heart Valve Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Angina <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Palpitations <input type="checkbox"/> Rhumatic Heart Disease <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Low Blood Pressure	_____
Urinary System Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Urgency <input type="checkbox"/> Painful Urination <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Nighttime Urination <input type="checkbox"/> Release when Sneeze/Cough <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney Infection	_____
Stomach & Intestine Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Ulcers <input type="checkbox"/> Bleeding <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea/Vomitting <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Intestinal Disease <input type="checkbox"/> Black Stool Intolerance to: <input type="checkbox"/> Milk <input type="checkbox"/> Eggs	_____
Endocrine Problems?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Panceas <input type="checkbox"/> Thyroid <input type="checkbox"/> Pituitary	_____

T.C. Initials _____
 OR Initials _____

History Of:	Specifics of Problems if YES:	Please Explain... Also indicate any Medication (dosage)
Liver Problems? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
Kidney Problems? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
Blood Problems? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Hemophilia <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Bleed Easily <input type="checkbox"/> Blood Clots <input type="checkbox"/> Had Stroke	_____
Chronic Disease Problems? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> HIV+ <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Infectious Disease <input type="checkbox"/> AIDS <input type="checkbox"/> Swelling <input type="checkbox"/> Tonsilitis <input type="checkbox"/> Excessive Colds	_____
Skin Problems? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Eczema <input type="checkbox"/> Dry <input type="checkbox"/> Oily <input type="checkbox"/> Itchy	_____
One Time Problems? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Mumps (at age ____) <input type="checkbox"/> Rhumatic Fever (at age ____) <input type="checkbox"/> Measles (at age ____) <input type="checkbox"/> Chicken Pox (at age ____)	_____
Heart Surgery Surgery? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Heart Valve (date ____) <input type="checkbox"/> Pacemaker (date ____) <input type="checkbox"/> Bypass (date ____) <input type="checkbox"/> _____ (date ____)	_____
Other Surgery? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tonsils (date ____) <input type="checkbox"/> Adenoids (date ____)	_____
Serious Injury? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Broken Bones (date ____) _____	_____
Occupational Disease? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
	(ADULTS)	_____

Habit Excesses? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Smoking (____ Packs/Day) for ____ years <input type="checkbox"/> Caffeine <input type="checkbox"/> Alcohol <input type="checkbox"/> Over Eating	_____
Exercise Regularly? <input type="checkbox"/> NO <input type="checkbox"/> YES	____ Hours <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	_____
Psychological Problems? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Psychiatric Disorder <input type="checkbox"/> Insomnia _____	_____
Presently Taking Medications? <input type="checkbox"/> NO <input type="checkbox"/> YES (Dosage?)	<input type="checkbox"/> Birth Control <input type="checkbox"/> Diuretics <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Blood Thinners <input type="checkbox"/> Heart <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Anticonvulsant <input type="checkbox"/> Insulin or similar drug	_____
Allergic Reactions? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Hay Fever <input type="checkbox"/> To Foods <input type="checkbox"/> To Metals/Plastics	_____
Drug Reactions? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Anti-Bacterial Drugs _____	_____
Anesthetic Reactions? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Local Anesthetic <input type="checkbox"/> General Anesthetic	_____

Child: Has the Patient Reached Puberty? Female started menstruation? NO YES AT WHAT AGE? ____ Males had voice change? NO YES AT WHAT AGE? ____
 Has a physician indicated that the patient is MATURING: EARLIER than normal? NO YES LATER than normal? NO YES NORMALLY? NO YES

Women: Are you pregnant now or do you think you might be? NO YES
 Do you anticipate becoming pregnant? NO YES

Family History Of:	Specifics of Problems if YES:	Comments on Family History of Disease
Diabetes? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
Cancer/Skin Cancer? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
Infectious Disease? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV+ <input type="checkbox"/> AIDS	_____
Heart Disease? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
High Blood Pressure? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
Organ Disease? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Liver <input type="checkbox"/> Kidney <input type="checkbox"/> Lung	_____
Kidney Disease? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
Lung Disease? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
Emotional Problems? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
Stroke? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____
Arthritis? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____	_____

T.C. Initials _____
 DR. Initials _____