



TODAYS DATE: \_\_\_\_\_

**PATIENT**

Name: \_\_\_\_\_ Prefers to be called: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

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

Contact Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status: Married Divorced Separated Single Widowed

Spouse's Name: \_\_\_\_\_

**DENTAL INSURANCE**

Insurance Coverage: yes no Insurance Co: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Group #: \_\_\_\_\_ SSN/ID: \_\_\_\_\_ Phone #: \_\_\_\_\_

**ADDITIONAL INFORMATION**

Family Dentist: \_\_\_\_\_ Date of Last Cleaning: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Date of Last Check-up: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

What are your main concerns regarding your teeth? \_\_\_\_\_

Have you had previous orthodontic treatment? \_\_\_\_\_

If yes; please provide approximate dates, summary of treatment, retainer types and dates worn : \_\_\_\_\_

\_\_\_\_\_

How would you like us to contact you? Call Email Text

**PLEASE ANSWER HEALTH HISTORY QUESTIONS ON THE BACK SIDE**

	Yes	No
1. Are you under a doctor's care at the present time?		
2. Are you presently taking any medication regularly?		
3. Have you ever been told you have a heart condition		
Do you require any premedication before dental appointments?		
4. Have you ever been told that your blood pressure is too high or too low?		
5. Have you ever had rheumatic fever or rheumatic heart disease?		
6. Do you bleed excessively following a cut or other injury?		
7. Are you allergic to any food, drug, or medicine?		
If so, please list :		
8. Do you have other allergies?		
9. Have you ever been treated for diabetes?		
10. Have you ever been treated for epilepsy?		
11. Have you ever been diagnosed with or treated for ADD, ADHD, OCD, Bipolar Disorder or Autism?		
12. Have you ever taken Cortisone, ACTH, or other steroid drug?		
13. Have you ever had a blood disease?		
14. Have you ever had a bone disease, or more than one bone fracture?		
15. Have you ever had a tumor or cancer?		
16. Have you ever had surgery?		
17. Have you had your tonsils and adenoids removed?		
18. Have you ever had a disease of the eyes, ears, nose, or throat?		
19. Have you ever experienced prolonged bleeding following a tooth extraction or oral surgery?		
20. Have you ever experienced difficulty when dental anesthetics (Novocain) were administered?		
21. Have you been diagnosed with having HIV or HIV-Related Complex?		
22. Have you had any serious illness other than those mentioned?		
23. Did you have any physical or genetic anomalies at birth?		
24. Have you had any accidents or injuries relating to your face, teeth , or head?		
25. Did you ever suck your thumb or fingers?		
26. Have you ever had any other oral habits (nail biting, lip biting, cheek biting, etc.)?		
27. Do you grind or clench your teeth?		
28. Did your primary ("baby") teeth erupt on time (6-9 months of age)?		
29. Has a dentist ever extracted any of your primary or permanent teeth?		
30. Have you ever had:		
a. Pain in your jaw joint when opening, chewing, or yawning?		
b. Limited jaw movement?		
c. Clicking or popping noises in your ears while chewing?		
d. Your jaw get stuck open or closed?		

If any of the above questions are checked yes, please explain next to the question.

**Signature** \_\_\_\_\_