Health History and Registration

Patient Information

PATIENT LAST NAME	**FIRST**	**MIDDLE**	**NICKNAME**
AGE	SEX: ○ MALE ○ FEMALE	DATE OF BIRTH	
STREET ADDRESS	CITY	STATE/PROVINCE	ZIP CODE
CELL PHONE	**HOME PHONE**	**WORK PHONE**	
E-MAIL	PATIENT'S SCHOOL / EMPLOYER		
DRIVER'S LICENSE NUMBER	**SOCIAL SECURITY NUMBER**		
PATIENT'S DENTIST	PHONE	DATE LAST SEEN	REASON

If Patient is a minor, Responsible Parties Name: Phone:

Additional Person Authorized on Account:

Emergency Contact: Phone:

Family Information (Minors)

MOTHER'S NAME	**PHONE**	**SSN**
EMAIL	**EMPLOYER**	
○ Check this box if Authorized to receive financial/account info		
FATHER'S NAME	**PHONE**	**SSN**
EMAIL	**EMPLOYER**	
○ Check this box if Authorized to receive financial/account info		
OTHER FAMILY INFO		

Dental Insurance Information (Primary Carrier)

PRIMARY POLICY HOLDER'S NAME	SSN	DATE OF BIRTH	
DENTAL INSURANCE COMPANY	GROUP NO.	SUBSCRIBER ID	
INSURANCE COMPANY ADDRESS	CITY	STATE/PROVINCE	ZIP CODE
INSURANCE COMPANY PHONE	INSURED'S EMPLOYER		
EMPLOYER ADDRESS		EMPLOYER PHONE	

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Altamonte Springs, FL 32714
(407) 682-0883

1454 W International Speedway Blvd
Daytona Beach, FL 32114
(386) 947-2063

bestsmiles
ORTHODONTICS
www.bestsmiles.com

2900 David Walker Drive
Eustis, FL 32726
(352) 589-5558

200 Treemonte Drive
Orange City, FL 32763
(386) 775-8707

Medical History

Now or in the past, have you had:

Y N Birth defects or hereditary problems?
Y N Jaw fractures, any major accidents?
Y N Rheumatoid or arthritic conditions?
Y N Endocrine or thyroid problems?
Y N Kidney problems?
Y N Diabetes?
Y N Cancer, tumor, radiation treatment or chemotherapy?
Y N Stomach ulcer or hyperacidity?
Y N Polio, mononucleosis, tuberculosis, pneumonia?
Y N Problems of the immune system?
Y N AIDS or HIV positive?
Y N Hepatitis, jaundice or liver problem?
Y N Fainting spells, seizures, epilepsy or neurological problem?
Y N Mental health disturbance or depression?
Y N Vision, hearing, tasting or speech difficulties?
Y N History of eating disorder (anorexia, bulimia)?
Y N Excessive bleeding or bruising tendency, anemia or bleeding disorder?
Y N High or low blood pressure?
Y N Cardiovascular or heart problem
Y N Skin disorder?
Y N Frequent headaches, colds or sore throats?
Y N Eye, ear, nose or throat condition?
Y N Hayfever, asthma, sinus trouble or hives?
Y N Tonsil or adenoid conditions?
Y N Osteoporosis?

Allergies or reactions to any of the following:

Y N Local anesthetics (Novocaine or Lidocaine)
Y N Aspirin
Y N Ibuprofen (Motrin, Advil)
Y N Penicillin or other antibiotics
Y N Sulfa drugs
Y N Metals (jewelry, clothing snaps)
Y N Latex (balloons)
Y N Acrylic
Y N Other substances (specify): _____

Y N Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.
Medication: _____
Taken for: _____
Medication: _____
Taken for: _____
Y N Do you currently have or ever had a substance abuse problem?
Y N Do you chew or smoke tobacco?
Y N Hospitalized? For: _____

Y N Other physical problems or symptoms? Describe: _____

Y N Being treated by another health care professional? Describe: _____

Y N Women only: Are you pregnant?

What are the main concerns with the patient's smile and bite?

_____

_____

What type of braces is the patient interested in? (check all that apply)

○ Traditional/Silver Brackets ○ Clear/Ceramic Brackets ○ Clear Aligners(Invisalign)

Whom may we thank for referring you to our office? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

PATIENT/GUARDIAN SIGNATURE | DATE

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ORTHODONTICS
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SPECIALIST IN ORTHODONTICS FOR CHILDREN AND ADULTS