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:

Additional Person Authorized on Account:

Emergency Contact: Phone:

Family Information (Minors)

RESPONSIBLE PARTY LAST NAME	FIRST	MIDDLE NAME/INITIAL	MARITAL STATUS

RESPONSIBLE PARTY STREET ADDRESS ○	CITY	STATE/PROVINCE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE

E-MAIL	SSN
RELATION TO PATIENT	DATE OF BIRTH

Check box if contact information is the same as above

OCCUPATION	EMPLOYER	ADDRESS

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

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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SPECIALIST IN ORTHODONTICS FOR CHILDREN AND ADULTS