Please complete both sides and bring to our office for your first appointment

PATIENT HISTORY FORM **Age:** ______ **Yrs.** ______ **Mos.**

Patient's Name ________________________________ **Date of birth:** ________________

Sex M / F Social Security No. ____________________ Home phone number ______________________

Address ____

Employer__________________________Length of employment________Work ph#___________________

Spouse____ Date of Birth_________________

Social Security No. ____________________ Home phone number _________________________

Address ____

Employer__________________________Length of employment________Work ph#___________________

CHILDREN/FAMILY MEMBERS ALREADY IN TREATMENT (CURRENT OR PREVIOUS)

NAME_________________________________ **NAME**_________________________________

NAME_________________________________ **NAME**_________________________________

Referring Person (s)- Whom we may thank?____

What would you like us to accomplish for you?____

Guarantor's Name (person responsible for payment & **INITIATING** treatment –**this is one AND the Same**

Name____Date of birth ____________

Social Security Number __________________________Relation to patient ____________________________

Current Address ____Telephone________________

E-Mail Address____

Orthodontic Insurance Coverage? YES____ NO _____

*If you answered "YES" to Orthodontic Insurance Coverage, then please provide the following information:

Primary Subscriber Name: _________________________ Date of Birth:__________**SS** #: ______________

Employer's Name & Address ____

Primary Ins. Co. Name ____ Phone # ______________________

Insurance Co.

Address _______________________________________**GROUP #**_______________________

Secondary Subscriber Name: _______________________ Date of Birth:__________**SS** #: ______________

Employer's Name & Address____

Secondary Ins. Co. Name _____________________________________

Insurance Co.

Address____**GROUP#**____________________

*NOTE: Complete insurance information is imperative to ensure accurate processing of your insurance claim.

I also understand this office may request pertinent medical, dental and financial history (credit report) related to the anticipated treatment.

SIGNATURE____ **DATE**_______________

DENTAL/MEDICAL HISTORY

Patient's Dentist Phone Number

Dentist's Address

Date of Last Visit Were any X-rays taken? Dentist's concerns

Speech Therapy: Y / N

Any prior ortho treatment: Y / N Orthodontist

Past Facial, Head or Neck Trauma: Y / N (Explain):

Past Dental Trauma: Y / N (Explain

HABITS: Thumb _________________ **Finger** _________________ **Mouth breather** ____

Nail Biter ___________________ **Use of Tobacco** ____________________________________ **Other** ____________________________

1. How often do you brush your teeth? ____________________
2. Are your teeth painful? Y N
3. Can you chew on both sides of your mouth? Y N
4. Have you had unusual bleeding with previous extractions surgery? Y N
5. Do you have any pain or discomfort, in the jaw-joint, face or neck? Y N
6. Are you aware of your jaws making clicking, popping or cracking noises? Y N
7. Have you ever been told you have TMD? Y N
8. Do you ever clench your teeth? Y N
9. Do your gums bleed? Y N
10. Do you floss regularly? Y N
11. Is there a history of gum disease? Y N
12. Are you aware of any gum recession? Y N
13. Have you ever had periodontal treatment? Y N

Patient's Physician ____ Phone Number _____________________

Physician Address ____

Does your child have any mental illness or developmental disability that requires special needs? Y N

Explain____

14. Are you presently under the care of a physician? Y N
    If so, why? _____________________________
15. Have you been a patient in a hospital in the past three years
    If so, what were you treated for? ____________________
16. Have you been in any other institution (weight reduction, drug or alcohol treatment, psychiatric, or other) in the past three years? Y N
17. Have you had a blood transfusion in the past three years? Y N
18. Do you perspire excessively at night? Y N
19. Do you have persistent diarrhea or recent weight loss? Y N
20. Do you have a purplish rash or persistent purplish bruise(s)? Y N
21. Have you ever had damaged or artificial heart valves, including heart murmur, rheumatic heart disease, or scarlet fever? Y N
22. Are you pregnant? (if applicable) __________________
23. Are you presently taking **any treatment drugs or medication?** Y N
    LIST____
24. Do you occasionally use or take recreational drugs? Y N
25. Are you allergic to drugs or medicine? Y N
    If so, which ones? ________________________________
26. Have you had prolonged coughing or coughed up blood? Y N
27. Have you ever had a blood test for hepatitis or AIDS? Y N
    Results were: Negative (no virus) __ Positive (virus present) __
28. Have you had canker sores, cold sores, fever blisters, or other sores on your lips, tongue, gums, genitals or body in the past three years? Y N
29. Do you require any pre-medication for dental or other treatment? Y N
    Please explain _______________________________________
30. **Are you under the care of any other dental specialist?** Y N
    Name ____

*Circle any of the following which you have had or now have (date to the left):

A. _____ AIDS
B. _____ allergies (including latex)
C. _____ anemia
D. _____ arthritis
E. _____ artificial heart valves
F. _____ artificial joints
G. _____ asthma
H. _____ bacterial endocarditis
I. _____ cancer treatment
J. _____ cardiac pacemaker
K. _____ cardiovascular disease
L. _____ chicken pox
M. _____ chronic cough
N. _____ congenital heart lesions
O. _____ cytomegalovirus (CMV
P. _____ diabetes
Q. _____ dizziness, fainting spell
R. _____ epilepsy
S. _____ glaucoma
T. _____ heart murmur
U. ______ heart trouble
V. ______ hepatitis
W. ______herpes
X. ______ high blood pressure
Y. ______ immune disorders
Z. ______ jaundice
AA._____ kidney treatment
BB. _____ measles
CC. _____ mitral valve prolapse
DD. _____ mononucleosis
EE. ______ mumps
FF. ______ organ transplant
FG ______ osteoporosis
GG.______ psychiatric treatment
HH.______ shortness of breath
II. _______ sinus trouble
JJ. _______ stroke
KK. ______ tuberculosis
LL.______ sexually transmitted diseases
MM. _____ chemotherapy
NN. _____ radiation therapy