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Welcome to our office! Please fill out this medical history to help us better serve you.

Date: _____ / _____ / _____

Patient Information

Name: _____ Preferred To Be Called: _____
School: _____
Home Address: _____ **City:** _____
State: _____ Zip Code: _____
Home #: ( ) _____ - _____ **Sex:** Male / Female
Birth Date: _____ / _____ / _____
Name and Ages Brother and Sister: _____
Nearest friend or Relative and their phone Number: _____

Referred By: _____
Dentist: _____ **Phone #:** ( ) _____ -_____
Physician: _____ Phone #: ( ) _____ -_____

Financially Responsibility Party Information

Name: _____ **Relationship to Patient:** _____
Address: _____ **City:** _____
State: _____ **Zip Code:** _____
Home #: ( ) _____ -_____**Cell #:** ( ) _____ - _____
Birth Date: _____/ _____ / _____ **SSN:** _____ - _____ - _____
Employer Name: _____ **Occupation:** _____
Address: _____ **City:** _____
State: _____ **Zip Code:** _____ **Work #:** ( ) _____ - _____
Email Address: _____

Dental Insurance Name: _____**Phone #:** ( ) _____-_____
Policy Holder's Name: _____ **Group #:** _____

Parent Information (Other than Financially Responsible)

Name: _____ **Relationship to Patient:** _____
Address: _____ **City:** _____
State: _____ **Zip Code:** _____
Home #: ( ) _____ -_____**Cell #:** ( ) _____ - _____
Birth Date: _____/ _____ / _____ **SSN:** _____ - _____ - _____
Employer Name: _____ **Occupation:** _____
Address: _____ **City:** _____
State: _____ **Zip Code:** _____ **Work #:** ( ) _____ - _____
Email Address: _____

Dental Insurance Name: _____**Phone #:** ( ) _____-_____
Policy Holder's Name: _____ **Group #:** _____

MEDICAL HISTORY

1. Is the Patient in good health? _____ Yes / No
2. Has your general health changed within the past year? _____ Yes / No
3. Are you currently under a physician's care? _____ Yes / No
4. Have you ever had major surgery, illness, or been hospitalized? _____ Yes / No
5. Are you taking any medication or drugs of any kind? _____ Yes / No
6. Are you allergic to any medication or latex? _____ Yes / No
7. Do you have high ( ) or ( ) low blood pressure? _____ Yes / No
8. Do you bleed easily, have anemia, or hemophilia? _____ Yes / No
9. Have you ever had an artificial joint, heart pacemaker, or rheumatic fever? ____ Yes / No
10. Do you have a heart murmur or heart problems? _____ Yes / No
11. Have you tested positive for **AIDS? _____** Yes / No
12. Have you had, or are you now being treated for venereal disease? _____ Yes / No
    Example: Syphilis or gonorrhea
13. Have you ever had sinus trouble, asthma, bronchitis, TB, emphysema, or other lung disease? Yes / No
14. Have you ever had hepatitis, jaundice, or other liver disease? _____ Yes / No
15. Have you ever had thyroid, kidney, or diabetic problems? _____ Yes / No
16. Have you ever been treated for mental or nervous disorder?
    Example: Epilepsy, Psychiatric treatment Yes / No
17. Have you ever taken a diet drug such as Phen Phen? _____ Yes / No
18. Women: Are you pregnant now? _____ Yes / No
    Do you anticipate becoming pregnant soon? _____ Yes / No

Dental Information

1. Has the patient ever had any injuries to the mouth, face, teeth, or jaw? _____ Yes / No
2. Are there any existing dental problems? _____ Yes / No
3. Does the patient have any gum problems? _____ Yes / No
4. Does the patient any habits such as finger or thumb sucking, tongue thrust,
5. mouth breathing, nail, lip, or cheek biting? _____ Yes / No
6. Any emotional, stress related, or psychologist problems? _____ Yes / No
7. Has the patient reached puberty? _____ Yes / No
8. Does the patient have ear pain, or ringing in the ears? _____ Yes / No
9. Does the patient's jaw click, lock, or have TMJ problems? _____ Yes / No
10. Does the patient have speech problems? _____ Yes / No
11. Does the patient have facial, jaw, or head pain? _____ Yes / No
12. Have the patient's tonsils or adenoids been removed? _____ Yes / No
13. What is your primary reason for seeking treatment? _____
14. Has the patient had previous orthodontic treatment? _____ Yes/ No
    Who? _____ When? _____
15. When was your last dental exam or cleaning? _____
16. How tall is Mom: _____ How Tall is Dad: _____

Assignment and Release

I certify that I, and / or my dependant(s), have insurance coverage with _____ and
Name of Insurance
assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent or Guardian Please Print name of Patient, Guardian

Relationship to Patient: _____ Date: _____ / _____ / _____

Doctors Signature: _____ Date: _____ / _____ / _____