

Advanced Orthodontics Health History Form

Patient's Name: _____ Age: _____ Birthdate: _____
Name you like to be called: _____ School: _____ Grade: _____
Hm Phone: _____ Wk Phone: _____ Cell Phone: _____
Email Address: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY

Name: _____ Marital Status: _____
Address: _____ City: _____ State: _____ Zip: _____
Mailing Address (if different): _____ City: _____ State: _____ Zip: _____
How long at this address? _____
Previous Address: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ Birthdate: _____ Relationship to Patient: _____
Employer: _____ Occupation: _____ No. of years employed: _____

INSURANCE INFORMATION

Insured's Name: _____ Insured's SS#: _____
Insurance Co: _____ Insurance Co. Address: _____
Phone: _____ Insured's Employer: _____
Do you have dual coverage? Yes No If yes: _____
Insured's Name: _____ Insured's SS#: _____
Insurance Co: _____ Insurance Co. Address: _____
Phone: _____ Insured's Employer: _____

MEDICAL/DENTAL HISTORY

Physician's Name: _____ Phone: _____
Dentist's Name: _____ Phone: _____
 Yes No Are you currently under any medical treatment? _____
 Yes No Do you have pain, clicking, and/or popping noises in the jaw? _____
 Yes No Are you aware of either clenching or grinding of teeth? _____
 Yes No Do you have frequent headaches? How often? _____
 Yes No Do you have ear problems? (Aches, ringing, dizziness, fullness) _____
 Yes No Do you have difficulty breathing through the nose? _____
 Yes No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting? _____
 Yes No Do you have speech problems, or are you in speech therapy? _____
 Yes No Have you had your tonsils and/or adenoids removed? _____
 Yes No Has there been any history of: Joint Swelling Asthma TB Aids Kidney
 Liver Condition Epilepsy Rheumatic Fever Other major illnesses? _____
 Yes No Do you bleed easily? _____
 Yes No Is there a tendency to faint or become dizzy? _____
 Yes No Do you have allergies? (Sulphur, penicillin, novocaine, etc.) _____
 Yes No Are you currently taking any medications? List: _____
 Yes No Do you have a heart condition? Yes No Do you pre-mediate? Yes No Cardiologist: _____
 Yes No Do you have sleep apnea? _____
 Yes No Do you smoke or chew tobacco? _____
 Yes No Have there been any injuries to the teeth? _____
 Yes No Have you had any permanent teeth extracted? _____
 Yes No Have we treated any other family members? Yes No Who: _____

I understand where appropriate a credit report may be obtained

Signature: _____ Date: _____