



New Patient Health History - Adult

**1. Patient Information**

First Name: \_\_\_\_\_ Middle Initials: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Female  Male Marital Status:  Single  Married

Street Address: \_\_\_\_\_ Apt./Unit #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred contact method:  Mobile Phone  Home Phone  Work Phone  Email  Text

**2. Responsible Party Information (if different from previous listing):**

First Name: \_\_\_\_\_ Middle Initials: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Female  Male  Other Marital Status:  Single  Married

Street Address: \_\_\_\_\_ Apt./Unit #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred contact method:  Mobile Phone  Home Phone  Work Phone  Email  Text

**3. How did you learn about our practice or whom may we thank for referring you?**

Referral Source  
 Google  Dentist  Social Media  Sign or Billboard  Insurance Provider List

Friend or family (enter name) \_\_\_\_\_ Other Website \_\_\_\_\_ Other \_\_\_\_\_

**4. What is your primary concern(s)?**

\_\_\_\_\_

**5. General Dentist Information:**

Dentist Name: \_\_\_\_\_ Dental visit in last 6 months?:  Yes  No Any scheduled treatments? \_\_\_\_\_

**6. Do you have Dental Insurance?**

Yes  No  Not Sure

**7. Primary Insurance**

Primary Insurance Company \_\_\_\_\_ Member ID / Policy # \_\_\_\_\_ Group Number \_\_\_\_\_

Patient Relationship to Insured <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	Insured Name _____	Insured Phone # _____	Insured Date of Birth _____
Insured Street Address _____	Insured City _____	Insured State _____	Zip Code _____

**8. Primary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.**

**9. Secondary Dental Insurance**

Secondary Insurance Company _____	Member ID / Policy # _____	Group Number _____	
Patient Relationship to Insured <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	Insured Name _____	Insured Phone # _____	Insured Date of Birth _____
Insured Street Address _____	Insured City _____	Insured State _____	Zip Code _____

**10. Secondary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.**

**11. Check if you have or have had any of the following:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Asthma/COPD      | <input type="checkbox"/> Bleeding abnormally |
| <input type="checkbox"/> Cancer Treatment  | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Fainting          | <input type="checkbox"/> GERD/Acid Reflux | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Heart problems    | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> HIV AIDS          | <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Rheumatic fever   | <input type="checkbox"/> Stroke           | <input type="checkbox"/> Tobacco use         |
| <input type="checkbox"/> None of the above |   |  |

**Other/Details:**  
\_\_\_\_\_

**12. Indicate any history of (check all that apply); If checked "Yes", please explain.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Thumb/finger sucking             | <input type="checkbox"/> Tongue and/or swallowing problems        | <input type="checkbox"/> Speech problems                       |
| <input type="checkbox"/> Loose teeth or broken fillings   | <input type="checkbox"/> Grinding and/or clenching of teeth       | <input type="checkbox"/> Tonsils and adenoids removed          |
| <input type="checkbox"/> Crowns/Bridges                   | <input type="checkbox"/> Root canals                              | <input type="checkbox"/> Mouth breathing                       |
| <input type="checkbox"/> Snoring                          | <input type="checkbox"/> History of wearing a mouthguard at night | <input type="checkbox"/> History of Periodontal disease        |
| <input type="checkbox"/> History of Periodontal treatment | <input type="checkbox"/> Mouth sores                              | <input type="checkbox"/> Injury to face or teeth               |
| <input type="checkbox"/> Jaw Pain                         | <input type="checkbox"/> Clicking or popping jaw                  | <input type="checkbox"/> Difficulty opening or closing jaw     |
| <input type="checkbox"/> Sensitivity when biting          | <input type="checkbox"/> Cold, hot, or sweets sensitivity         | <input type="checkbox"/> Food collection between certain teeth |
| <input type="checkbox"/> None of the above                |   |  |

**Other/Details:**  
\_\_\_\_\_

**13. Please list any allergies you may have:**

	Allergy
1	

**14. List medications you are currently taking and the correlating diagnosis:**

	Medication	Diagnosis
1		

15. Have you had any serious illnesses or operations? If yes, please describe.

---

16. What treatment option(s) interest you?

Aligners

Clear/Metal Braces

Retainers

Other:

---

17. If treatment is recommended, how soon would you like to get started?

ASAP

Within the week

Within the month

Other:

---

18. What payment option(s) would you like to review?

No-Interest Monthly Payment

Payment in Full w/Special Courtesy

HSA/FSA

Other:

---

19. Is there anything else you would like us to know before your visit?:

---

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

---

Signature

---

Date