



Updated Health History

1. Patient Information:

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

2. Primary Responsible Party Information:

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

3. Secondary Responsible Party Information (optional):

First Name: _____ Middle Initials: _____ Last Name: _____

Date of Birth: _____ Gender: Female Male Other
Marital Status: Single Married Domestic Partner Separated Divorced Widowed

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

4. General Dentist Information:

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

5. Do you have Orthodontic Insurance?

Yes No

6. 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
_____	_____	_____	_____

7. 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.

8. 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
_____	_____	_____	_____

9. 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.

10. Check if your child has or has 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 |

Other/Details:

11. 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 certain teeth | <input type="checkbox"/> Food collection between |

Other/Details:

12. Has patient reached puberty?

- Yes No

13. Please list any allergies:

	Allergy
1	

14. List current medications and the correlating diagnosis:

	Medication	Diagnosis
1		

15. Any serious illnesses or operations? If yes, please describe.

16. 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