Patient Information

Mr.☐ Mrs.☐ Ms.☐ Miss☐ Dr.☐ Rev.☐ Other:_____

Patient Name:_____
First Middle Last (Name Called)

Birthday:_____

Hm Ph:_____ Cell Ph:_____ Wk Ph:_____

Address:_____

Address:_____

City, State Zip Code:_____

Sex M☐ F☐ SSN:_____ Race:_____

Last Dental Check Up:_____ Dentist:_____

Patient's Email Address:_____ Physician_____

Who referred you to our practice?_____

Any Medical Problems?_____

Responsible Party Information

Mr.☐ Mrs.☐ Ms.☐ Miss☐ Dr.☐ Rev.☐ Other:_____

Responsible Party Name:_____
First Middle Last (Name Called)

Birthday:_____

Home Phone:_____ Work Phone:_____

Address:_____

Address:_____

City, State ZipCode:_____

Sex M☐ F☐ SSN:_____ Relationship to Patient:_____

Is this Responsible Party Financially Responsible for Charges? yes☐ no☐

Is this the Primary Person who brings patient to appointments? yes☐ no☐

Insurance Company:_____

Group Number:_____ Phone:_____

Address:_____

Employer:_____

Additional Responsible Party:_____

Additional Information

List Family Members that are currently in our practice:_____

_____

_____

Hobbies & Interests:_____

_____

_____

Medical/Dental History

For the following questions circle **yes, no, or ?** (Don't know/Don't understand). Further explanation can be done in the spaces at the end of this questionnaire. (Questions below pertain only to the patient.)

MEDICAL

Yes No ? Vision, hearing, task, or speech difficulties?

Yes No ? Birth defects or hereditary problems?

Yes No ? Rheumatoid or arthritic conditions?

Yes No ? Endocrine or thyroid problems?

Yes No ? Kidney problems?

Yes No ? Diabetes?

Yes No ? Cancer or tumor treatment?

Yes No ? Stomach ulcer problems?

Yes No ? Polio, mononucleosis, tuberculosis, pneumonia?

Yes No ? Hepatitis, jaundice or liver problems?

Yes No ? AIDS or HIV Positive?

Yes No ? Fainting, seizures, epilepsy?

Yes No ? Mental health or behavioral problems?

Yes No ? Anemia, or bleeding disorder?

Yes No ? High or low blood pressure?

Yes No ? Chest pain, shortness of breath or swelling ankles?

Yes No ? Heart trouble or Cardiovascular problems, heart murmur?

Yes No ? Skin disorder?

Yes No ? Frequent headaches, colds, or sore throats, eye, ear, nose problems?

Yes No ? Hayfever, asthma, or sinus trouble, hives, or seasonal allergies?

Yes No ? Allergies to drugs or antibiotics? (List in Explanation Section)

Yes No ? History of substance abuse?

Yes No ? Have adenoids or tonsils been removed?

Yes No ? Adult Females: Are you pregnant or do you anticipate being pregnant? N/A

Yes No ? Are you in good health?

DENTAL

Yes No ? Have any teeth been removed that were not loose?

Yes No ? Chipped or injured permanent teeth?

Yes No ? Extra or congenitally missing teeth?

Yes No ? Any injuries to teeth or face?

Yes No ? Sensitive teeth or toothaches?

Yes No ? Jaw fractures, cysts, or mouth infections?

Yes No ? Bleeding gums, bad taste, or mouth odor?

Yes No ? Thumb or finger sucking habit until age _____

Yes No ? Abnormal swallow (tongue thrusting)?

Yes No ? Mouth breathing or snoring or lips apart at rest?

Yes No ? Tooth grinding or jaw clenching?

Yes No ? Pain or soreness in jaw muscles or around your ears (TMJ problems)?

Yes No ? Constant cheek, tongue or lip biting?

Yes No ? Difficulty in chewing or jaw opening?

Yes No ? Any relative with similar tooth or facial features?

Yes No ? Any previous orthodontic exam or appliances worn?

What is your primary concern? Why are you here?

_____

_____

_____

I have read and understand the above questions. I will not hold Dr. Ross, Dr. Munn or staff responsible for any errors or omissions that I have made in completing this form. If there are changes later to this health history, I will inform this practice.

_____

Signature or Signature of Legal Parent or Guardian Date

List any medications the patient is taking _____

Any other medical, dental, or surgical problems not covered by this health history? Yes, no or ?

Explanation:

_____

_____

_____

_____