Health History:

Primary Care Physician: _____

Have there been any serious illness or surgeries? (please include hospitalizations) Yes or No If yes, please describe:

_____

Please indicate by marking **Yes or No** if any of the following apply:

	Yes	No		Yes	No		Yes	No
AID/HIV	□	□	Diabetes	□	□	Pacemaker	□	□
Anemia	□	□	Emphysema	□	□	Radiation treatment	□	□
Arthritis/Rheumatism	□	□	Epilepsy	□	□	Sinus trouble	□	□
Artificial heart valves	□	□	Fainting/dizziness	□	□	Skin rash	□	□
Artificial Prosthesis	□	□	Headaches	□	□	Stroke	□	□
Asthma	□	□	Heart murmur	□	□	Swollen feet/ankles	□	□
Blood disease	□	□	Heart problems	□	□	Swollen neck glands	□	□
Cancer	□	□	Hepatitis type __	□	□	Thyroid problems	□	□
Chemotherapy	□	□	High blood pressure	□	□	Tonsillitis	□	□
Circulatory Problems	□	□	Kidney disease	□	□	Tuberculosis	□	□
Congenital heart problems	□	□	Liver disease	□	□	Ulcer	□	□
Facial ticks	□	□	Low blood pressure	□	□	Pregnant	□	□
Cortisone treatments	□	□	Mitral valve prolapse	□	□	Psychiatric treatment	□	□

Please list any medication being taken that would affect dental health: _____

_____

Please list any allergies that are present, including plastics or metals: _____

Authorizations:

- I authorize my insurance company to pay the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize use of this signature on all insurance forms.
- I authorize the orthodontist to release all information necessary to secure payment of benefits.
- I authorize that I am financially responsible for all charges whether or not paid by insurance. (Charges may be incurred for the following: x-rays, study models, extractions, replacement retainers, etc.)
- I have received a copy of or have been advised of the HIPPA notice of Privacy Policy of the Practice.

Patient/Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

MEDICAL HISTORY UPDATES (TO BE COMPLETED YEARLY AS TREATMENT PROGRESSES)

Have there been any changes in medical history? Yes or No (please circle one)

If yes, please indicate changes: _____

_____

Patient/Parent signature: _____ Date: _____

Have there been any changes in medical history? Yes or No (please circle one)

If yes, please indicate changes: _____

_____

Patient/Parent signature: _____ Date: _____

Have there been any changes in medical history? Yes or No (please circle one)

If yes, please indicate changes: _____

_____

Patient/Parent signature: _____ Date: _____

Today's date: _____ (please complete the front and back of form)

Tell us about your child:

Name: _____ Birth date _____

Street Address: _____

City: _____ Zip Code: _____

Home #: _____ Dentist: _____

Emergency Contact: _____ Phone: _____

Parent #1's Information: Are you responsible for this account/billing? Yes or No (please circle one)

Name: _____

Street Address: _____

City: _____ Zip Code: _____

Home #: _____ Cell # _____ Carrier: _____

E-mail: _____ (for appointment notifications)

Birth date: _____ Social Security Number: _____

Dental Insurance Information: Employer: _____ Group # _____

Insurance Company Name: _____

Parent #2's Information: Are you responsible for this account/billing? Yes or No (please circle one)

Name: _____

Street Address: _____

City: _____ Zip Code: _____

Home #: _____ Cell # _____ Carrier: _____

E-mail: _____ (for appointment notifications)

Birth date: _____ Social Security Number: _____

Dental Insurance Information: Employer: _____ Group # _____

Insurance Company Name: _____

Dental History:

Previous orthodontic treatment? Yes or No When was the last dental visit? _____

How often does he/she brush? _____ How often does he/she floss? _____

Please indicate if your child has, had or does any of the following by marking **Yes or No**

	Yes	No		Yes	No
Bad breath	☐	☐	Jaw pain or tenderness	☐	☐
Bleeding gums	☐	☐	Lip or cheek biting	☐	☐
Missing teeth	☐	☐	Loose teeth	☐	☐
Burning sensation on tongue	☐	☐	Mouth breathing	☐	☐
Chew on one side of mouth	☐	☐	Mouth pain	☐	☐
Dry mouth	☐	☐	Pain around ears	☐	☐
Fingernail biting	☐	☐	Broken fillings	☐	☐
Food collection between teeth	☐	☐	Sensitivity to temperatures	☐	☐
Thumb or finger sucking	☐	☐	Sensitivity while biting	☐	☐
Grinding teeth	☐	☐	Smoker/tobacco chewer	☐	☐
Gums swollen or tender	☐	☐	Sores, blisters or growths	☐	☐

Over>>