Patient Information and Health History Form (part 1)

Patient Information

First Name | Preferred (First) | Last Name

Date of Birth | Age | Gender | Are you on facebook? ☐ Yes

Address | City | State/Prov

Address Line 2 | Country | Zip/Postal Code

Primary Phone | Other Phone | Email Address

Person bringing Patient to their appointment:

Patient's chief concern:

If Invisalign? Are you interested in conventional braces?

Who referred | General Dentist name | Last checkup date

Family or friends in practice:

Previous orthodontic consult? | Previous Orthodontist | Consult Date

Responsible Party A Information

Relationship | First Name | Last Name | DOB

Address | City | State/Prov

Address Line 2 | Country | Zip/Postal Code

Primary Phone | Other Phone | Email Address

SSN | Occupation | Employer | Work Phone

Responsible Party B Information

Relationship | First Name | Last Name | DOB

Address | City | State/Prov

Address Line 2 | Country | Zip/Postal Code

Primary Phone | Other Phone | Email Address

SSN | Occupation | Employer | Work Phone

Patient Information and Health History Form (part 2)

First Name | Preferred (First) | Last Name

Dental insurance available for orthodontics? _____ May we check this for you? **No**

Are Insurance Subscriber and Responsible Party the same? **No**

Subscriber (if different than RP) | Insurance Company | Group Number

SSN | Date of Birth | Phone Number (Insurance)

Subscriber 2 (if different than RP) | Insurance Company 2 | Group Number 2

SSN 2 | Date of Birth 2 | Phone Number 2 (Insurance)

Medical History

Medications _____

Allergies _____

Major Illness _____

Operations _____

Accidents _____

Abnormal Bleeding/Hemophilia _____	Gastrointestinal Disorders _____	Nervous Disorders _____
Anemia _____	Heart Problems _____	Pneumonia _____
Arthritis _____	Heart Murmur _____	Radiation/Chemotherapy _____
Asthma or Hayfever _____	Hepatitis/Liver Problems _____	Rheumatic Fever _____
Bone Disorders _____	Herpes _____	Tuberculosis _____
Congenital Heart Defect _____	High Blood Pressure _____	Tumor or Cancer _____
Diabetes _____	HIV / Aids _____	
Epilepsy _____	Kidney Problems _____	

Other Conditions _____

Dental History

Apprehensive about dental care _____	Discomfort from teeth or gums _____	Brush daily _____
Presently in dental pain _____	Pain, tenderness or noise in either jaw _____	Floss daily _____
Unfavorable reaction to dentistry _____	Grind or clench teeth _____	Flouride treatments _____
Missing or extra permanent teeth _____	Frequent sore throats _____	Frequently chew gum _____
Injury to face, jaw, teeth, or mouth _____	Speech problems/therapy _____	Requires premedication _____
Bleeding gums _____	Snores during sleep _____	
Oral habits _____	Frequent headaches _____	Pregnant _____
Mouth breathing _____	Neck/shoulder pain _____	Menstruation started _____

Signature _____ Date _____