

Tiny Teeth

Kids' Dentistry & Orthodontics

Patient Health History Form

Patient

Date: _____ How did you hear about our office? _____
Patient's First name: _____ Middle Initial: _____ Last name: _____ Age _____
Birthdate: _____ Sex: Male Female Social Security Number # _____
Hobbies, activities: _____
Home address: _____ City, State, Zip code: _____
Cell phone: _____ Home phone: _____
Email address(es): _____

Parent/Guardian

Mother's Name _____ Mother's DOB _____
Father's Name _____ Father's DOB _____
Patient lives with (mark all that apply) Mother Father Stepmother Stepfather Grandparent(s) Other

Dentist

Patient's dentist: _____ Address, City, State: _____
Last seen: _____ Reason: _____ Next appointment: _____
Other dentists/ dental specialists now being seen: Name: _____ City, State _____

General Information

What concerns do you have about your teeth? _____
Have any other family members been treated in this office? _____ If yes, please name them: _____
Have you had any previous orthodontic treatment? _____ If yes, please describe: _____
Why did you select our office? _____

Dental Insurance

Insurance Company: _____ Phone #: _____
Primary policy holder's full name: _____ Birthdate: _____
Member or Subscriber ID #: _____ Group #: _____
Social Security #: _____ Relationship Patient: _____
Policy Holders Address: _____ City, State, Zip code: _____
Employer: _____ Employer Address: _____
Does this policy have orthodontics benefits? YES NO I don't know
Secondary Insurance Company: _____ Phone #: _____
Secondary policy holder's full name: _____ Birthdate: _____
Member or Subscriber ID #: _____ Group #: _____
Social Security #: _____ Relationship Patient: _____
Policy Holders Address: _____ City, State, Zip code: _____
Employer: _____ Employer Address: _____
Does this policy have orthodontics benefits? YES NO I don't know

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions mark "yes", "no", or "not sure".

Medical history

Now or in the past, have you had:

- | | | | |
|------------------------------|-----------------------------|-----------------------------------|--|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Birth defects or hereditary problems? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Bone fractures, or major injuries? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Any injuries to face, head or neck? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Arthritis or joint problems? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Cancer, tumor, radiation treatment or chemotherapy? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | AIDS or HIV positive? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Hepatitis, jaundice or other liver problem? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Polio, mononucleosis, tuberculosis, pneumonia? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not Sure | Seizures, fainting spells, neurologic problem? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Vision, hearing, or speech problems? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | History of eating disorder (anorexia, bulimia)? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | High or low blood pressure? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Excessive bleeding or bruising, anemia? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Heart defects, heart murmur, rheumatic heart disease |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Angina, arteriosclerosis, stroke or heart attack? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Frequent headaches or migraines? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Frequent ear infections, colds, throat infections? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Do you frequently breathe through your mouth? |

Have you had allergies or reactions to any of the following:

- | | | | |
|------------------------------|-----------------------------|-----------------------------------|---|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Latex (gloves, balloons) |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Metals (jewelry, clothing snaps) |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Acrylics |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Local anesthetics (Novocaine, lidocaine, xylocaine) |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Aspirin |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Ibuprofen (Motrin, Advil) |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Penicillin |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Other antibiotics |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Plant pollens |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Animals |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Foods |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Other substances |

Dental History

Now or in the past have you had:

- | | | | |
|------------------------------|-----------------------------|-----------------------------------|---|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Permanent or extra (supernumerary) teeth removed? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Supernumerary (extra) or congenitally missing teeth? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Chipped or injuries primary or permanent teeth? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Any sensitive or sore teeth? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Bleeding gums, bad taste, or mouth odor? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Jaw fractures, cysts, infections? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Any teeth treated with root canals or pulpotomies? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | History of speech problems or speech therapy? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Food impaction between teeth? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Mouth breathing habit or snoring at night? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Frequent oral habits (sucking finger, chewing pen, etc.)? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> Not sure | Teeth causing irritation to lip, cheek or gums? |

<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Abnormal swallowing (tongue thrust)?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Tooth grinding or clenching?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Clicking, locking in jaw joints?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Soreness in jaw muscles or face muscles?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Ringing in ears, difficulty in chewing or opening jaw?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Have you ever been diagnosed with gum disease or pyorrhea?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Not sure	Have you ever had an orthodontic consultation or treatment before

Patient Health Information

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take: _____

Do you take antibiotic pre-medication before any dental procedures? YES NO

Have you smoked any substance or vaped? YES NO If yes, what is the frequency? _____

Have you chewed tobacco YES NO Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush?: _____ How often do you floss?: _____

Women: Are you pregnant? YES NO Are you trying to become pregnant? YES NO

Release and Waiver

I authorize release of any information regarding my orthodontics treatment to my dental and/ or medical insurance company.

I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

I give permission to perform an examination and to take any diagnostic records deemed necessary for an evaluation and treatment.

I have received a copy of the privacy rules for this provider.

Printed Name: _____ Signature: _____ Date: _____