Patient Information & Health History

Prefered Pronouns:_____/_____/_____ DATE:_____

PATIENT NAME:_____ DOB:_____

PERSON RESPONSIBLE FOR ACCOUNT:_____

ADDRESS:_____ APT#:_____ PHONE # :_____

CITY:_____ STATE:_____ ZIP CODE:_____

Email: _____

Dental Insurance:_____ Subscriber:_____

Subscriber DOB(if different from patient:)_____ Subscriber or Member ID: _____

General Dentist:_____ FSA/HSA: ☐

School(If K-12):_____

Release of Orthodontic Insurance Benefits: _____ Plans on changing or losing the insurance in the foreseeable future: ☐

Dental History

CHIEF ORAL COMPLAINT:_____

DATE OF LAST DENTAL EXAM:_____ PREVIOUS MAJOR DENTAL WORK? IF YES, WHEN? _____

PLEASE INDICATE WITH AN (X) IF YOU HAVE OR USE ANY OF THE FOLLOWING:

- O Teeth Sensitive
- O Bleeding Gums
- O Food impaction
- O Clenching or grinding
- O Burning of tongue
- O Swelling or lumps in mouth
- O Pain in ear
- O Unusual sounds in ear
- O Bad Breath
- O Unpleasant taste
- O Unfavorable dental experience
- O Complications from extraction
- O Periodontal treatment
- O Orthodontic treatment
- O Mouth Breathing
- O Oral habits (fingernail biting... etc.)
- O Smoking of any kind
- Texture of Toothbrush_____
- Frequency of brushing_____
- O Do you use dental floss
- O Inter dental stimulators
- O Water jet device
- O Disclosing tablets or solutions
- O Fluoride supplements

Medical History

PHYSICIAN'S NAME: _____ DATE OF LAST PHYSICAL EXAM:_____
(Only if relevant Medical issue is present)

PLEASE INDICATE WITH AN (X) IF YOU HAVE OR USE ANY OF THE FOLLOWING:

- O Allergies to drugs
- O Allergies to anesthetics
- O Any hearth ailments
- O High blood pressure
- O Neurological problems
- O Radiation treatments
- O Excessive bleeding
- O Anemia of blood problems
- O Arthritis
- O Sinus problems
- O Asthma
- O Hay fever or allergies in general
- O Diabetes
- O Kidney problems
- O Liver problems or Hepatitis
- O Malignancies
- O Psychiatric care/emotional
- O Rheumatic fever
- O Immune System Disorders (Aids, HIV, ARC)
- O Stroke
- O Eye disorders
- O Tonsillitis
- O Tuberculosis

Any current or past condition that may prevent us from taking X-rays or doing Orthodontics:

_____

HOW DID YOU HEAR ABOUT US?

- O Yelp
- O Google
- O Friend/Family
- O Just Walking By
- O Facebook
- O ZocDoc
- O Dentist_____
- O Patient_____
- O Other_____

_____
(Name of the Referrer)

PATIENT SIGNATURE:_____ DATE: _____
(If under 18, then Guardian)

FOR OFFICE USE ONLY

Review Medical_____ Review Benefits & Risks_____