

# Health History Form



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## Patient Information

Today's Date \_\_\_\_\_  
 Male  Female

**Name** \_\_\_\_\_  
First MI Last

Preferred Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

## Medical/Dental History

Primary Dentist \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Are you taking any prescription medication?  Yes  No

If so, which ones? \_\_\_\_\_

Are you currently taking a bisphosphonate for osteoporosis?  Yes  No

List any drug sensitivities \_\_\_\_\_

### Please check all of the following that apply

- Asthma  Jaw Joint Pain  Teeth Grinding  
 Diabetes  Bone Disorders  Heart Condition  
 Epilepsy  ADD/ADHD  AIDS/HIV  
 Hepatitis

Have you been informed of any missing/extra teeth?  Yes  No

Has an orthodontist previously been consulted?  Yes  No

Previous orthodontic treatment?  Yes  No

Thumb sucking habit or tongue thrust?  Yes  No

## Child Patients Only

School \_\_\_\_\_

Child's Hobbies/Interests \_\_\_\_\_

Is the patient adopted?  Yes  No

Boy: Has his voice changed?  Yes  No

Girl: Has she started menstruation?  Yes  No

If yes, Month/Year \_\_\_\_\_

Who does he/she live with?

- Both Parents Together  Both Parents Separately  Mother  Father  Other

## Resp. Party Information

**Name** \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Work # \_\_\_\_\_

- Married  Divorced  Separated  
 Single  Widowed

Resp. Party Email \_\_\_\_\_

**Spouse/Other** \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Work # \_\_\_\_\_

Are there any other children that you would like us to evaluate?  Yes  No

### Family members previously seen:

Whom may we thank for referring you to our office?  
\_\_\_\_\_  
\_\_\_\_\_

## Insurance (if not previously given to us)

### Primary Dental Insurance

Group Number \_\_\_\_\_

Insured's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Company & Address \_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_\_ ID/SS# \_\_\_\_\_

### Secondary Dental Insurance

Group Number \_\_\_\_\_

Insured's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Company & Address \_\_\_\_\_  
\_\_\_\_\_

X

Signature of Parent/Patient/Guardian

Date