New Patient Health History Form

About you

Today's Date ____________

Name ________________________________ Preferred Name/Nickname ___________________

Address ____________________________ City _______________ State _____ Zip ____________

Cell Phone ___________ Birth Date _________ Age ______ Sex M / F Employer ___________

Day-time Phone ____________ Email ___________________ Spouse's Name _______________

How did you hear about our office? ____

What is the reason you are seeking an orthodontic evaluation? ___________________________

Has an orthodontist been consulted previously? Y / N Reason ____________________________

Please list other family members seen in our office and their relationship to you

____

Medical Health Information

Have you been hospitalized for any surgical procedure of serious illness? Y / N

Name of your physician _________________________________ Phone ____________________

Do you have or have you had any of the following disease or conditions (circle those that apply)

Diabetes	Fainting Spells Seizures	AIDS, HIV Positive
Stroke	Scarlet Fever, Rheumatic Heart Diseases	Herpes, Fevers Blisters
Asthma	Allergies (medicine or other)	Joint Replacement or Implant
Hepatitis	Latex or Nickel Sensitivity/Allergy	Excessive Bleeding or Bruising
Tonsillitis	High or Low Blood Pressure	Drug or Alcohol Dependency
Pregnancy	Tonsils/Adenoids Removed	Heart Defect, Murmur,Disease

Do you or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? Y / N If so, which drug? ___________________________________

Do you have any disease, condition, or problem not listed that you think we should know about? Please Explain: ____

Are you taking any medication at this time? Y / N If yes, Please list _______________________

Dental Insurance Information

Primary Insurance Company Name ____

Address ____ Group/Plan Number _______________

Primary Policy Holder Name __________________ SSN ______________ Date of Birth ________

Secondary Insurance Company Name ____

Address ____ Group/Plan Number _______________

Secondary Policy Holder Name __________________ SSN ____________ Date of Birth ________

Do you participate in a flex plane? Y / N

Dental Health Information

Are you experiencing any dental problems? Y / N Date of last dental visit _________________
How often do you brush and floss each day? Brush ____ per day Floss _____ per day
Dentist ____ Phone ________________________

Do you have or have you had any of the following disease or problems? (circle those that apply)

Tongue Thrust	Jaw Pain(Joint, Ear, Side of Face)	Extra Adult Teeth
Sore or Bleeding Gums	Tooth Sensitivity (Heat, Cold Sweets)	Fear of Dental Work
Permanent Tooth Extraction	Previous Orthodontic Treatment	Clenching of Grinding
Difficulty Chewing	Head/Neck, Jaw or Tooth Injury	Finger or Lip Habit
Missing Permanent Teeth	Clicking or Popping of the Jaw Joints	

Photo Release

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I acknowledge that the above information is correct. I will notify Dr. Lee of any changes that occur after this date. I hereby authorize Dr. Lee and his team to perform an initial orthodontic evaluation/exam

Signature ____ Date ____________________