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Health History Form

Patient Information

Patient's Name:_____ Age:_____ Birthdate:_____

Name you like to be called:_____ Home Phone:_____

School:_____ Grade:_____ Social Security#: _____

Address:_____
City State Zip

Do you play any musical instrument? ☐ Yes ☐ No

Who may we thank for referring you to our office?_____

Responsible Party

Name:_____ Marital Status:_____

Address:_____
City State Zip

Mailing Address:_____
(if different) City State Zip

How long at this address? _____ Previous Address: _____
City , State, Zip

Email: _____ Home#: _____ Cell#: _____

Employer:_____Occupation:_____No of years employed:_____

Dental Insurance Information

Insured's Name: _____ Insured's SS#:_____

Insurance Co:_____ Phone:_____

Insurance Co. Address: _____

Group#:_____ Insured's Employer::_____ Subscribers DOB:_____

Medical/Dental History

Physician's Name: _____ Phone: _____

Dentists Name: _____ Phone:_____

☐Yes ☐No Are you currently under any medical treatment?

_____

☐Yes ☐No Do you have pain, clicking, and/or popping noises in the jaw?

_____

☐Yes ☐No Are you aware of either clenching or grinding of teeth? _____

☐Yes ☐No Do you have frequent headaches? How often? _____

☐Yes ☐No Do you have ear problems? (aches, ringing, dizziness, fullness)

_____

☐Yes ☐No Do you have difficulty breathing through the nose?_____

☐Yes ☐No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?_____

☐Yes ☐No Do you have speech problems, or are you in speech therapy?

_____

☐Yes ☐No Have you had your tonsils and/or adenoids removed?_____

☐Yes ☐No Has there been any history of? ☐Joint Swelling ☐Asthma ☐TB ☐Aids ☐Kidney ☐Liver Condition ☐Epilepsy ☐Rheumatic fever ☐Other major illnesses? _____

☐Yes ☐No Do you bleed easily? _____

☐Yes ☐No Is there a tendency to faint or become dizzy?_____

☐Yes ☐No Do you have allergies? (sulphur, penicillin, novocaine, etc.)

_____

☐ Yes ☐ No Are you currently taking any medication?

List: _____

☐ Yes ☐ No Do you have a heart condition?

☐ Yes ☐ No Do you pre-medicate?

☐ Yes ☐ No Cardiologist:_____

☐ Yes ☐ No Do you have sleep apnea? _____

☐ Yes ☐ No Do you smoke or chew tobacco? _____

☐ Yes ☐ No Have there been any injuries to the teeth? _____

☐ Yes ☐ No Have you had any permanent teeth extracted? _____

☐ Yes ☐ No Have we treated any other family members?

Who:_____

Signature: _____ Date: _____

☐ I confirm I will send my Drivers license to the office via email prior to my appointment.

PRIVACY CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form falls under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

_____
Patient Name

_____
Guardian/Patient Signature

_____ _____
Print Name Date