

HEALTH HISTORY FORM



ADULT PATIENT INFORMATION

Date _____

Patient's name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address? _____ Home phone _____ Work phone _____

Previous Address (If less than 3 years) _____

Cell Phone _____ Birthdate _____ Social Security # _____

Email Address _____ Marital Status: Single Married Widowed Separated Divorced

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthday _____ Work phone _____

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

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes No If yes: _____

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

Signature _____

Updates (date & initial) _____

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MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any operations? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Have you ever smoked or chewed tobacco? _____

Yes No Have seen a physician in the last 12 months? Why? _____

Female Patients only:

Yes No Are you pregnant? _____

Yes No Has menstruation started? _____

Check any of the medical conditions below that you have had or currently have.

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> Abnormal bleeding/Hemophilia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis/Liver problems | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Radiation/Chemotherapy | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma or Hayfever | <input type="checkbox"/> Bone Disorders |
| <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumor or Cancer | |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No Have your wisdom teeth been removed? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth, or teeth? _____

Yes No Is any part of your mouth sensitive to temperature? Where? _____

Yes No Is any part of your mouth sensitive to pressure? Where? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have "tension" headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Michael Bicknell to perform a complete orthodontic evaluation.

Signature: _____ Date: _____